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The Journal

of the

Michigan State Medical Society

Published under the Direction
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1961



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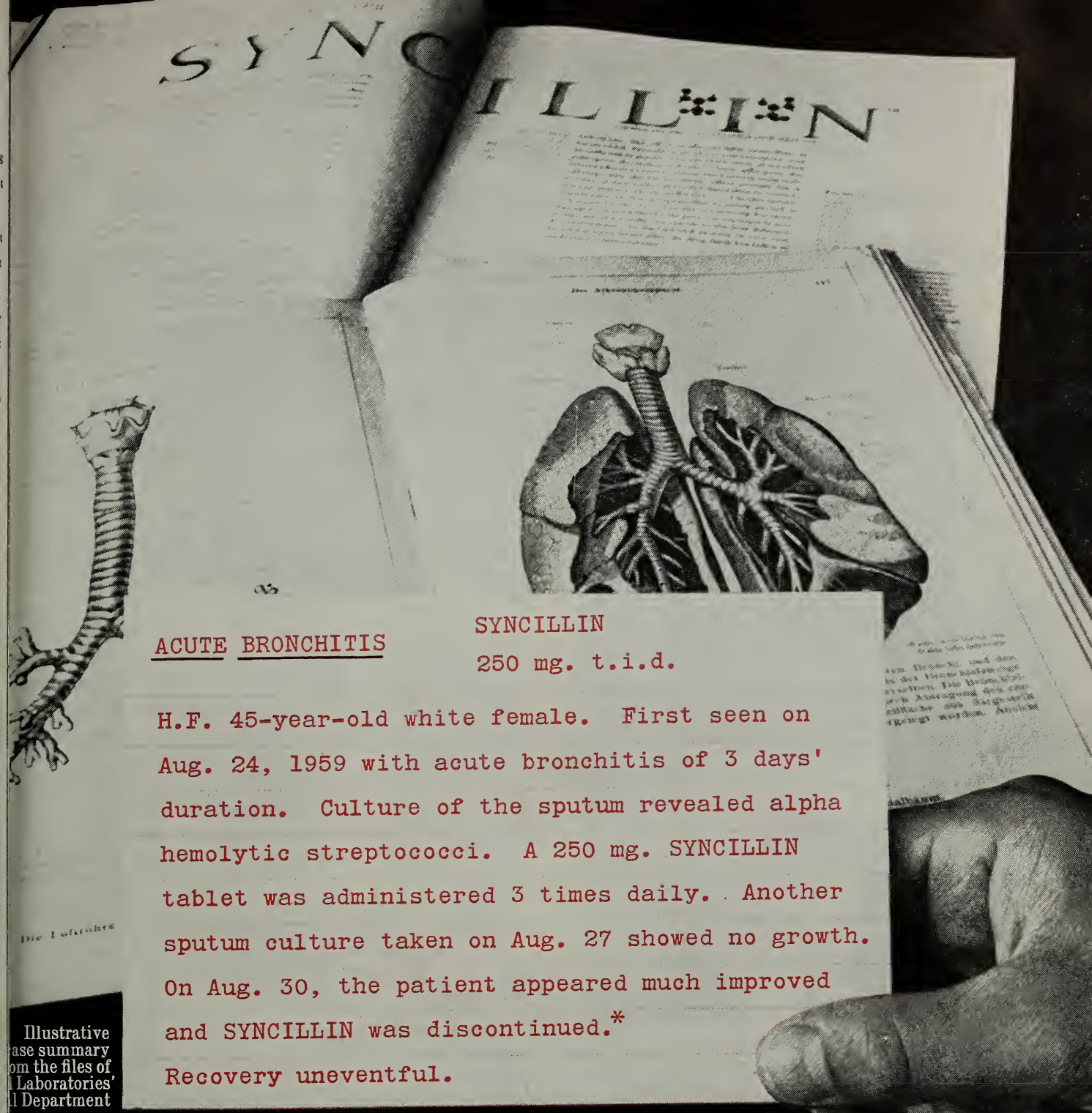
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Delegates

	Term Expires
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W. A. Hyland, M.D., Grand Rapids, *Chairman*	1961
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C. I. Owen, M.D., Detroit	1961
Wm. Bromme, M.D., Detroit	1962
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	Term Expires
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President's Page

SEE YOU THERE!



All activities of the Michigan State Medical Society seek to equip each member of the profession to serve society better. One of these important projects certainly is the Michigan Clinical Institute.

Another outstanding Michigan Clinical Institute program, developed for *YOU*, will shine with scientific stars at the Sheraton-Cadillac Hotel, Detroit, March 8-9-10.

The Michigan State Medical Society is unique among state medical societies in that it offers the membership two major postgraduate education meetings each year. The Annual Session is held in the fall and the Michigan Clinical Institute in the spring.

The 1961 MCI was planned specifically to help the practicing physician in his daily work. The excellent refresher course will feature 42 nationally-recognized leaders in many fields of medicine.

If you are unable to attend the entire MCI, you can take advantage of the convenient "block system." Lectures on the same general specialty will be grouped again to help M.D.'s with major areas of interest. Please refer to the full program printed in this number of The Journal.

New! A series of "discussion groups" has been organized as a novel aspect of the 1961 MCI. These instructional classes on vital topics will open the day's activities each morning at 8:00 a.m. and run for exactly one hour.

MSMS is fortunate again to be able to present closed-circuit color television demonstrations and lectures for two and one-half hours daily, through the cooperation of Smith, Kline and French Laboratories of Philadelphia.

Each of the MCI speakers has been carefully chosen, each of the topics has been selected because of its importance to *YOU* and the total program of lectures, television teaching, discussion groups, color motion pictures and scientific and technical exhibits, go together to make the 1961 MCI one that you will want to attend to keep yourself "up-to-date." See you there!

Kenneth H. Kuson

Discussion Groups Added to MCI Program, March 8-10



"Learn today and apply tomorrow" could well be the slogan for the 1961 Michigan Clinical Institute to be held in Detroit, March 8-10.

Program Committee Chairman John Sigler, M.D., Detroit, said the total program was planned to help the practicing physician in his daily work. He explained that small discussion groups or teaching classes are scheduled to lead off the daily programs, running from 8:00 to 9:00 a.m. This is an important innovation for the Institute, he said.

* * *

MCI GENERAL CHAIRMAN Milton A. Darling, M.D., Detroit, announces that the 1961 MCI will open on Wednesday morning and conclude on Friday afternoon, thus eliminating the Tuesday afternoon session.

Closed circuit color television programs will be telecast daily from Detroit Memorial Hospital arranged by a committee chaired by D. H. Kaump, M.D., Detroit, through the cooperation of Smith, Kline & French Laboratories of Philadelphia.

Scientific papers will be "blocked" into segments of the program as in previous years. Wednesday morning will be devoted to Surgery, with Trauma featured that afternoon. Thursday morning will cover Heart and Rheumatic Fever, with Internal Medicine gaining the spotlight at 2 p.m. Friday morning will feature Obstetrics-Gynecology.

* * *

FOR THE CONVENIENCE of MSMS members attending the MCI refresher course, the Committee on Arrangements has again placed the registration desk on the fourth floor near the scientific assembly room.

Appointment of the News Committee for the 1961 MCI includes C. L. Weston, M.D., Chairman, Owosso; J. J. Coury, Jr., M.D., Port Huron; A. B. Gwinn, M.D., Hastings; D. H. Kaump, M.D., Detroit; C. A. Payne, M.D., Grand Rapids; and M. R. Weed, M.D., Detroit.

Co-sponsor Course at U-M

A Postgraduate Course in Rheumatic Fever, Rheumatic Heart Disease and Congenital Heart Disease will be presented at the University of Michigan Medical Center, March 13-17. Outstanding speakers have been obtained for this course, co-sponsored by the Michigan Heart Association, University of Michigan Medical Center, Wayne State University College of Medicine and the Michigan State Medical Society.

HIGHLIGHTS of MSMS Council Meeting

Meeting of November 16, 1961

Sixty-three items were discussed at this meeting of The Council held in Kalamazoo. Chief in importance were:

- Progress Report on new MSMS Headquarters Building was presented by President K. H. Johnson, M.D., Lansing, for the Big Look Committee. The contractor is making splendid progress and the building should be ready for occupancy by middle March or early April. President Johnson also reported that Mrs. L. Fernald Foster desires to contribute a lectern in The Council's Room, in memory of the late MSMS Secretary; also that Congressman Charles E. Chamberlain, Lansing, has donated to the new building a United States flag which has flown over the U. S. Capitol.

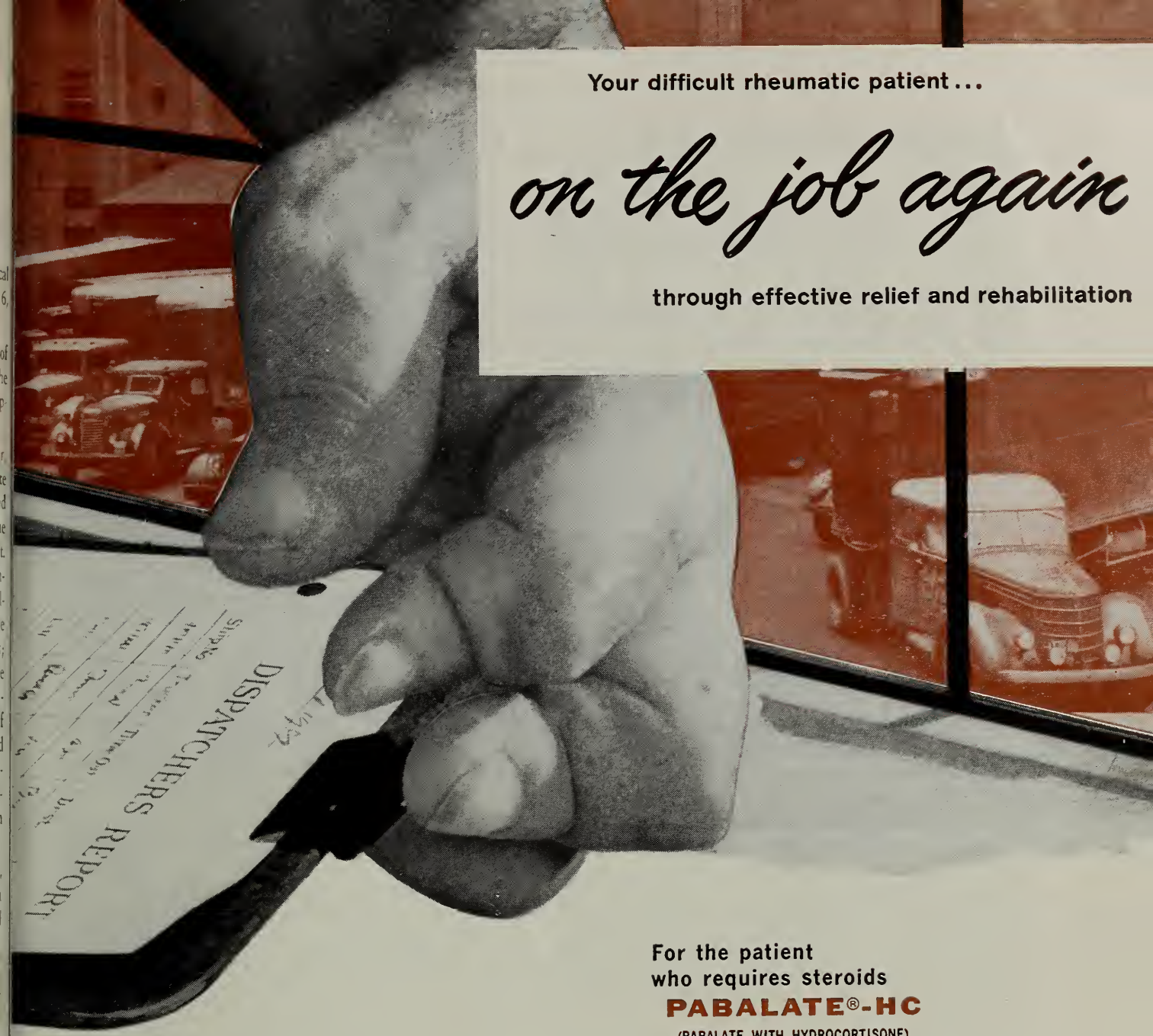
 The President's report also outlined recent progress of the Campaign for Freedom.
- The Program for the 1961 County Secretaries-Public Relations Seminar, to be held in East Lansing, January 28-29 (to include a tour of the new MSMS headquarters building) was considered and approved. This includes the Annual Awards Dinner to be held Saturday evening, January 28.
- Report on the development of a new County Society Secretaries' Handbook was given by W. M. LeFevre, M.D., Muskegon, Chairman of the County Societies Committee of The Council. This booklet will be distributed at the County Secretaries-Public Relations Seminar of January 28-29, in Lansing.
- The 1960 House of Delegates actions of especial interest to The Council were reviewed, including Resolutions 5, 6, 7, 9, 13, 17, 19, 23, 24, 25, 39, 40, 41, 47, 52, 54. The Council voted that all material and records in connection with the MSMS Seal of Assurance Plan and M-75 participating agreements be turned over to Michigan Medical Service. Actions to implement Resolutions 5, 6, 9, 24, 25, 39, 40, and 52 were taken.
- The report of the Finance Committee, meeting of November 16, including the financial report for the month and bills payable, was presented and approved.
- Council Chairman H. J. Meier, M.D., Coldwater, reported he was working on a project to amalgamate and streamline Committees of The Council, and that his appointments would be presented to The Council at its December 14 meeting in Detroit. The Council recommended that the Advisory Committee to the Executive Director be made a Standing Committee of The Council and that this be recommended to the 1961 House of Delegates; and that the Education Liaison Committee be made a Special Committee of The Council. The Chairman's recommendations on the reorganization of special committees of The Council was approved with thanks. It was emphasized that each committee should have its duties, purposes, and responsibilities delineated, and that a Vice Chairman should be appointed to each committee.
- President-Elect O. K. Engelke, M.D., Ann Arbor, was appointed to the Centennial Committee which is charged with arranging the 1965 (100th) Annual Session of the State Society.
- Résumé of Council policy actions for the past year. Chairman Meier reported that the Council's policy actions for the last twelve months had been codified. Mimeographed copies were distributed to Council members. A simple indexing system is being devised.
- Report on Michigan counties using the 1959 Uniform Fee Schedule for Governmental Welfare Agencies was presented to The Council, as follows: Benzie, Calhoun (less 40%), Charlevoix, Crawford, Genesee, Jackson, Mackinac, Macomb (less 20%), Manistee, Mecosta, Menominee, Newaygo, Ontonagon, Osceola.
- The date for the dedication of the new MSMS Headquarters Building was set as Sunday, May 28, 1961. A meeting of The Council was called for the preceding day.
- Recognition of retiring AMA Delegate W. D. Barrett, M.D., Detroit, included drafting of a resolution to be introduced by the Michigan delegation into the November, 1960, AMA House of Delegates meeting in Washington, D. C., covering his loyal

(Continued on Page 18)

MSMS Council to Use "Foster Lectern"

A generous gift of a lectern has been accepted with grateful thanks by The Council for the new Michigan State Medical Society headquarters building.

Gift of Mrs. L. Fernald Foster, Detroit, the "Foster Lectern" will be used in The Council Meeting Room. The gift is in memory of L. Fernald Foster, M.D., who served so ably for 24 years as MSMS Secretary.



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Highlights of MSMS Council Meeting

(Continued from Page 16)

service to medicine, to the AMA, and to MSMS over the years. The Council also nominated Doctor Barrett as President for a Day to the MSMS Committee on Awards.

- The President appointed the 1960-61 members of the new MSMS Cancer Control Committee; he reported that A. E. Heustis, M.D., had been appointed to the Postgraduate Medical Education Committee, and asked the advice of The Council on personnel of the new Medical Care Study Committee authorized by the 1960 House of Delegates.
- A letter of thanks was authorized to be sent to all members of The Councilor District Medical Care Insurance Committees which during the past several years served as reference committees in problems involving Michigan Medical Service matters.
- Michigan Medical Service President G. Thomas McKean, M.D., Detroit, reported on matters of mutual interest concerning Blue Shield and sought the advice of The Council as to what committee of component societies might now be utilized to which various questions and problems (to take the place of CDMCIC's) might be referred; also what type of communications should go to Michigan doctors regarding transfer of all participating agreements from MSMS to Michigan Medical Service with The Council deciding that this information should go in the MSMS Secretary's Letter to all members.
- Matters of mutual interest were discussed with Michigan Health Commissioner A. E. Heustis, M.D.
- Poll of Council members re day on which future meetings of The Council should be held: Chairman Meier reported that a mail poll indicated a desire to continue meetings on Wednesdays.
- Appointments: (a) MSMS representative to National Conference on Medical Aspects of Sports, Washington, D. C., November 27: R. E. Anderson, M.D., Flint, was appointed; (b) MSMS representative to Planning Committee for the Leadership Conference on Health Education, Battle Creek, January 27-28: Robert H. Trimby, M.D., Lansing; (c) News Committee for 1961 MCI: C. L. Weston, M.D., Owosso, Chairman; J. J. Coury, Jr., M.D., Port Huron; A. B. Gwinn, M.D., Hastings; D. H. Kaump, M.D., Detroit; C. A. Payne, M.D., Grand Rapids; and M. R. Weed, M.D., Detroit.
- Reports: 1. John W. Rice, M.D., Jackson, on his attendance at the American Association of Medical Assistants convention in Dallas, Texas, October 16.

 2. Otto J. Preston, M.D., on his attendance at the Joint Conference of Chairmen of State Medical Society Committees on Industrial Health, Charlotte, North Carolina, October 10, 1960.

 3. Wilfrid Haughey, M.D., on his attendance at the Medical Editors Conference, Lexington, Kentucky, October 15-16, 1960.



Appointed Historian

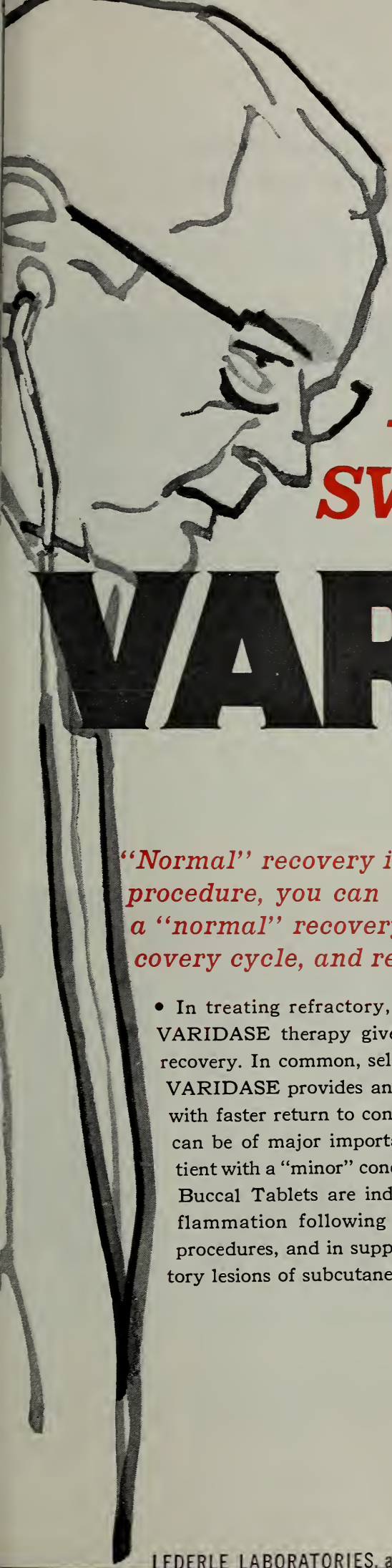
William J. Stapleton, Jr., M.D., Detroit, has been appointed Historian for the Michigan State Medical Society by The Council.

A resolution calling for the appointment of an MSMS Historian was introduced by the Wayne County Medical Society and approved at the 1960 House of Delegates. The resolution declared that "it would be in the best interest of the Michigan State Medical Society to have an historical record of its distinguished past and distinguished future."

Congratulations, Historian Stapleton!

MEDICAL MEETINGS AND CLINIC DAYS

1961	*Events*	*Location*
January 28-29	County Secretaries—Public Relations Seminar	East Lansing
February 10-11	Michigan Heart Days	Detroit
March 8-10	Michigan Clinical Institute	Detroit
April 6	Ingham County Spring Clinic	Lansing
May 22-25	Michigan Health Council Annual Conference	Flint
June 16-17	Upper Peninsula Medical Society	Menominee



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Photos Help Tell Story of 1960 Annual Session



Paul Dudley White, M.D. *(left)* after his Biddle Lecture at the 1960 MSMS Annual Session was presented a certificate of recognition by Milton A. Darling, M.D.





Mrs. Betty Lou Willey *(left)*, of Port Huron, is the new president of the Michigan State Medical Assistants Society, succeeding Mrs. Reta V. Stahl, Albion, retiring president.

A fine piece of glassware was presented at the Annual Session by MSMS to Mrs. William G. Mackersie, of Detroit *(left)* in recognition of her elevation to the presidency of the Woman's Auxiliary to the American Medical Association. She is the first Michigan woman ever to hold that high position. Admiring the gift is Mrs. Paul Ivkovich *(right)*, new president of the Woman's Auxiliary to MSMS.



Past presidents of the Michigan State Medical Society take time out from their special luncheon at the MSMS Annual Session for an official photograph. The former leaders of MSMS, left to right, seated, are Doctors H. H. Cummings, Arch Walls, W. S. Jones, C. E. Umphrey, and Henry Cook; and left to right, standing, are Doctors L. W. Hull, J. Milton Robb, G. W. Slagle, R. J. Hubbell, G. B. Saltonstall, Wilfrid Haughey, Milton A. Darling, Henry R. Carstens, and Otto O. Beck.

What They Said About The 1960 MSMS Annual Session

I thoroughly enjoyed your well-attended meetings and was more than impressed with the enthusiasm of the audiences.

It was a real pleasure to be one of your Guest Speakers.—Robert H. Barter, M.D., *Washington, D. C., essayist.*

* * *

I enjoyed thoroughly, the privilege of participating in the Assembly. My dermatologic colleagues and I were impressed with the many interesting questions presented to the Dermatologic Panel.—Donald J. Birmingham, M.D., Cincinnati, Ohio, essayist.

* * *

I enjoyed very much my first visit to the Michigan State Medical Society meeting and I was very pleased that we had such a good audience.—Hugh R. Butt, M.D., Rochester, Minnesota, essayist.

* * *

Mrs. Collins and I would like to thank you very much for making one of your guest speakers and his wife extremely comfortable during their stay in Detroit. I must say that your hospitality program including the idea of having a host and hostess for each guest speaker and his wife is a commendable system.

I also want to thank you for the very fine accommodations at the Sheraton-Cadillac, for the fruit which arrived shortly after we did, for the corsage which my wife appreciated very much.

After I arrived home I received a clipping from the "Detroit Free Press" with a report on the news conference with Mrs. Pearson. This clipping was encased in a very attractive little folder which had appropriate remarks on it.

Wherever I have gone people seem to have heard about the Michigan State Medical Society and the manner in which they put on their programs.—Ralph T. Collins, M.D., *Rochester, New York, essayist.*

* * *

This note is to tell you how much I enjoyed taking part in the Michigan State Medical Society Meeting last week and to express my sincere appreciation for your kind hospitality. It was quite apparent to me that all of you had made a great effort to make those of us from out of town feel more at home. This was greatly appreciated, I can assure you.—John B. Gross, M.D., Rochester, Minnesota, essayist.

* * *

May I assure you that it was indeed a pleasure and that I considered it an honor to be with you at the 95th Annual Meeting of the Michigan State Medical Society in Detroit.—Ruth Guttmann, M.D., New York, New York, essayist.

* * *

I must say that I enjoyed very much being there. The hospitality was wonderful.

Thank you again for inviting me to your most excellent program.—Robert W. Hollenhorst, M.D., Rochester, Minnesota, essayist.

* * *

I wish to thank all those concerned with inviting me to participate in the 1960 MSMS Annual Session. The hospitality was outstanding.—Leonard L. Lovshin, M.D., Cleveland, Ohio, essayist.

* * *

I was very much impressed with the meeting and thoroughly enjoyed being there. Needless to say, the cordiality extended to me was very heart warming.—Malcolm H. Merrill, M.D., Berkeley, California, essayist.

* * *

I enjoyed participating in the program and hope that I was of some help to you all.—Harry M. Spence, M.D., essayist.

* * *

I want to compliment the officials of the Michigan State Medical Society on the efficient arrangements that were made for this Medical Society meeting. I had a thoroughly enjoyable time during my brief visit in Detroit. It was indeed a pleasure to participate in the activities of the 1960 Annual Session.—E. Clinton Texter, Jr., M.D., Chicago, Illinois, essayist.

* * *

It was a great honor to be invited to be one of your guest speakers and I am very happy to learn that the program was received so favorably. It was a great pleasure to meet the members of your Society and also to see so many of my old friends. My visit to Detroit was very brief but very enjoyable.—Henry J. Tumen, M.D., Philadelphia, Pennsylvania, essayist.

* * *

I assure you that I thoroughly enjoyed my visit to Detroit and the privilege of participating in the Michigan State Medical Society program at its ninety-fifth Annual Session.

Everything possible was done to make my trip comfortable and pleasant and I do appreciate everyone's thoughtfulness. —R. Lomax Wells, M.D., *Washington, D. C., essayist.*

* * *

I should like to thank you and the members of the Michigan State Medical Society for all the courtesies shown me during my recent visit to Detroit. I have never before attended or participated in a meeting which was so well organized and well managed as that of your society.—J. Robert Willson, M.D., Philadelphia, Pennsylvania, essayist.

* * *

This is to express my sincere thanks for the opportunity of visiting the Michigan State Medical Society annual meeting and the courtesies extended to me as a representative of the Ontario Medical Association.

It was most interesting to view the method of presenting the business of your Society and I enjoyed the privilege of meeting the Presidents of other State Societies during my visit. I believe that such communication is beneficial to all physicians and I hope that we will be in a position to reciprocate at our next annual meeting.—J. C. Allison, M.D., Toronto, Ontario.

* * *

Mrs. Hesseltine and I enjoyed, very much, being guests of the Michigan State Medical Society. I appreciate, especially, your thoughtfulness in the corsage to my wife; and we both appreciate your generosity and hospitality for the entire time we were there.—H. Close Hesseltine, M.D., President, Illinois State Medical Society, Chicago.

(Turn to Page 22)

ADAMS
MICRO-HEMATOCRIT CENTRIFUGE

Safe! Stops Fast!
Quiet! Quick!



Features-

SAFE—Locking the centrifuge top depresses the safety switch—will not operate until top is closed and secured. Disc which covers tubes in head may be stored in centrifuge cover while loading head. Centrifuge cover will not close until disc is removed. Eliminates hazard of forgetting to cover tubes prior to centrifugation.

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QUICK—Head speed is 12,000 RPM . . . test takes just 3 minutes.

STOPS FAST—An automatic brake brings head to full stop in 1½ minutes—a fraction of the time required by other machines.
Head (CT-2910) holds 24 capillary tubes 75 mm or smaller, including 32 mm.
Interchangeable combination head (CT-2915) holds 8 capillary tubes and 8 serum tubes.

CT-2900—ADAMS MICRO-HEMATOCRIT CENTRIFUGE, High Speed. Complete with one head and cover (CT-2910), to hold 24 capillary blood tubes 75 mm or smaller, including 32 mm. For 110-115 volt AC. (50-60 cycle).....$195.00

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801 S. Brown Street Jackson, Michigan

What They Said About the 1960 MSMS Annual Session

(Continued from Page 20)

I wish to let you know how much I enjoyed my visit to the 1960 Annual Session of the Michigan State Medical Society. I was very impressed with the democratic manner in which you conducted your work in the House of Delegates relative to Blue Shield, and the high standard of program in the Scientific Sessions.—CLARENCE JACOBSON, M.D., President, Minnesota State Medical Association, Saint Paul.

* * *

Once again, may I thank you and the Society for your kind and generous treatment to me. I want also to compliment you on a difficult meeting well managed and certainly with a good overall outcome.—DONALD STUBBS, M.D., *Washington, D. C., President, Blue Shield Medical Care Plans.*

* * *

Permit me to take this opportunity to express my gratitude and appreciation to the Michigan State Medical Society for the opportunity to attend the recent meetings of your House of Delegates. This was a most rewarding and informative experience and certainly put into a much sharper focus the many socio-economic factors involved in medicine. Although time limitation prevented me from seeing and hearing all that interested me I definitely feel that my time was well spent and was, in a very real way, an educational experience. —DAVID G. TUBBERGEN, Senior Class President, University of Michigan, Ann Arbor.

National Recognition

The American Society of Association Executives presented three awards during 1960 and one of them was to William J. Burns, executive director of the Michigan State Medical Society. The plaque for the best executive of a state-wide organization was awarded to Mr. Burns by a judging committee of university leaders. In many ways, the award honors MSMS for its ambitious, progressive program of service to the medical profession and the general public.

New Flag Displayed

An American flag—that flew over the Capitol in Washington, D. C.—is proudly displayed now at the Michigan State Medical Society building. The flag was presented to MSMS by Congressman Charles E. Chamberlain, of Lansing. It will have a place of prominence in the new MSMS headquarters.

Say you saw it in the Journal of the Michigan State Medical Society

Vis Medicatrix Naturae

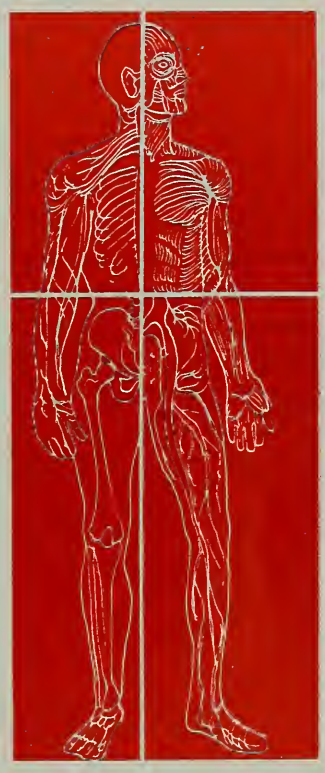
John M. Dorsey, M.D.
Detroit, Michigan

> Certainly no one needs insight more than the physician.
>
> James Howard Means, M.D.

THE ORIGIN of Medicine can be found only in the instinct of self-preservation. Medicine arose out of a man's sensing his very own identity *in his living* of his fellowman's distressing self-experiences, in a man's creating *his own personal* views of his suffering fellowman. My studies of history have not revealed just when the idea first occurred to a man that his own life course could be a planned selfhood. However, with the birth of that self-consideration his self-training, including the Art and Science of Medicine, was called into being.

The History of Medicine is an account of the fortune of physicianary appreciation that the curative art and science is based upon the individual (patient) variant, upon each patient's unique way of discovering (diagnosing) and understanding (treating) himself. It is practical to note: as the origin of medicine occurred in individual man so its future lives in the future of every human individual. The medical historian observes that a physician's energy is spent gaining experience in the practice and investigation of *his* life. As Goethe said, "Experience disciplines man every day."

Medicine doubtlessly started with the concept of help itself. Help is only recognizable as self-help when it *consciously* benefits self. Whether or not I am aware that I owe all of my realization of my world to the fact that my life creates my all, has nothing to do with this truth of my life's creativity. It does have to do with my mental health, however. Consciousness of my mind's powers produces, and therefore is directly proportionate to, my mental strength and health. It is said in Dhammapada (246 B.C.), "Whatever a hater may do to a hater, or an enemy to an enemy, a wrongly directed mind will do us greater mischief."



All Heal Is Self-heal

> The man is free, we say, who exists for his own sake and not for another's.
>
> Aristotle.

As long as the medical profession has existed, so has the precious medical insight: *every human being has natural healing power.* The only-and-all fact of human individuality is the only-and-all basis of medical theory and practice. The hygienic truth that all medical

Editor's Note: This paper is being published simultaneously in Japan as part of a "Festschrift" honoring the sixtieth birthday of Dr. Shuzo Naka, professor and chairman of the department of psychiatry at Osaka City University, and a close friend of Dr. Dorsey.

force occurs in no other place than in its occurrence in a specific individual is, as a rule, largely overlooked. However, it alone provides a frame in which it is possible to describe all of the medical truth of human wholeness.

Plato regarded the physician's specialized way of life as an ideal towards which everyone of every walk of life might direct himself. Thomas Jefferson grew the insightful appreciation of medical discipline lived by the ancient Greek. An essential part of Jefferson's ideal of universal education (of equal opportunity) was his introducing the study of medicine in his University of Virginia as a cultural self-experience desirable for every educated American. The emperor Tiberius "diagnosed" every man who attained the age of thirty years as either a fool or a physician.

This medical perspective that every human being has no choice other than to be his own physician, is now being gradually restored to medical living. In his practice, the doctor of medicine activates it particularly by way of two clinical developments: (1) the patient's educating himself about his health status, and (2) the patient's treating himself with grateful appreciation of his powers of self-help. In his preclinical work, the medical student activates it particularly by way of two basic science developments: (1) by growing his self-image of his doctorhood as requiring constant observation of the inviolability of individuality, and (2) by preparing himself as a specialist in the treatment of his actual and potential health vicissitudes. All I am and have, and ever can be and can have, is myself. Therefore, my comprehensive self-orientation is a health ideal upon which the whole consequence of my life must depend.

It cannot be repeated too often, every person has the exclusive and unique ability to help himself to maintain and restore his health balance. No one can have any part of this health activity for him, nor can he have it for anyone else. Furthermore, only he can augment his homeostatic medical power, by undergoing specific medical (self) experience on needy occasions. Thus, if he needs some special medical self-knowledge with regard to his heart, or kidney, he can pursue his personal medical education (as a conscious self-activity) by having his physician reveal what he (his physician) has cultivated of his own medical enlightenment with regard to the care of his heart, or kidney, as the case may be. To this bracing and reviving medical force (present only in the individual life of man, animal, or plant) the ancients assigned a Latin name: *vis medicatrix naturae.*

In his justly renowned Medical Dictionary (extolled by Osler as his favorite) Dr. Robley Dunglison lists as cognate terms under *Vis Medicatrix Naturae: Vis conservatrix, Autocratia, Autonomia, Autocratoria, Authygiansis, Autotherapeia, Physiatricē, Physioautocratia, Physiautocratia, Physioautotherapia,* (F) *Force médicatrice.*

Hippocrates termed *physis* (nature) the power of the vital forces of each human being to cope with health difficulties. By this *physis,* he meant *human* nature. The Greek expression for *vis medicatrix naturae* was *Nouson Physeis Ietroi.* By concentrating upon the life source and life developments *within the individual,* Hippocrates first freed the physician from his recurring illusion that one life can have anything to do with another life. Thus, the Greek physician added systematic knowledge of himself (the "Know thyself" formula of Thales) to his medical theory and practice.

Claude Bernard described Hippocrates' health orientation: "The first steps in scientific medicine taken by Hippocrates involved a doubt about the curative results of empirical methods and the appeal to the laws of living organisms to effect the cure of the sick." Bernard added, "While recognizing how direful for the patient it may be to use empirical medicaments to disturb the tendencies of nature when they are favorable, men must have asked themselves, on the other hand, whether it might not be possible, and useful to the patient, to disturb and change them when they were bad." The all-important medical truth to attend to here is: every patient *lives* his own "medicament" in the only way possible for him, namely, as an experience (a development) of his own nature. The only meaning any "medicament" has for any patient is: the meaning his nature makes of it (by his experiencing it). Thus, neither chemotherapy nor psychotherapy nor any other kind of therapy can offer itself as an exception to *vis medicatrix naturae.*

Even the pathological activities of the human organism are actually part of its helpful efforts towards recovery. More than 100 years ago, Virchow (who



The Author

JOHN M. DORSEY
M.D.

established the first pathological institute in Berlin in 1856) conceived pathology as a beneficent compensatory adjustment of biological law, deriving its meaning of "abnormality" from the fact that its life-favoring value is not duly appreciated. How true, Pasteur! "Intuition is given only to him who has undergone long preparation for receiving it."

Historical References

> The student obtaining knowledge and skill only at the top levels of the modern medical skyscraper should know something of the foundation structures and the service plants in the basement and sub-basement if he is to be something more than a technician.
>
> WILLIAM F. PETERSON, M.D.

Medical insights implicit in wholesomely self-conscious terms such as "self-heal," "self-cure," "self-care," "self-reverence," are deserving of fullest elaboration, for in them the human mind reaches its highest health developments. "I dressed the wound and God healed it," is the memorable writing of Ambroise Paré on the walls of the school of medicine at Paris. Of the sacred disease, epilepsy, "it is in no way more divine, no more sacred than other diseases, but has a natural course from which it originates like other affections," recorded insightful Hippocrates (who claimed *everything* to be human and *everything* to be divine). "Physician, heal thyself," the beloved physician Luke prescribed as his medicinal Arabian proverb. "To discover the nature of the dividing soul . . . or the principle of action of nerves," study the workings of the individual; "take instruction on the subject from an anatomist," stated Galen. "Reason dictates that disease is nothing else but Nature's endeavors to thrust forth with all her might the morbific matter for the health of the patient," reported Sydenham, the "English Hippocrates."

In the *Lancet* of 1897, Dr. Wilkinson stated the case of native medical self-help: "The *vis medicatrix naturae* is a power, a vital resistance to disease. Most protective processes are grouped together as 'symptoms'; whereas they should be labeled 'hereditary treatment'." He genially added that ignoration of the fact that *vis medicatrix naturae* "has already been in charge of the case for days, when we first approach with our mixtures and tabloids, is at least a mistake in medical ethics."

Today every medical doctor is aware of this innate hygienic disposition (commonly called "a good constitution") and is aware that it can be strengthened or weakened depending upon the way his patient chooses (finds it necessary) to live himself. Every physician is also alert to the therapeutic value in his patient's creating for himself an "atmosphere of cure," particularly in the form of his (self-experienced) nursing and medical help. Too, every physician is aware that the conscious sense of well-being can be dangerously deceptive, that a "flight into manifest feelings of health" may appear to offer a guarantee of a clean bill of health which is hardly warranted.

In the *British Medical Journal* (November, 1900), Dr. A. H. Carter noted:

> "But for the natural tendencies of the body towards health when disturbed by disease, the art of healing could not exist."

In 1902, Dr. Alfred T. Schofield wrote:

> "The *'vis'* is a fine illustration of the power of the mental factor in Pathology if not in Medicine. So great, indeed, is this natural power that not the most skilled combination of drugs is of any avail without its aid, while the most haphazard remedies of the purest empiricism can accomplish marvels if backed by this ever-present force. But for this marvellous power, a morbid disturbance once set up would inevitably continue to the point of annihilation; for treatment addressed to the living body *is absolutely meaningless* except as an appeal to such powers of resistance as a patient possesses. When these powers of the unconscious mind fail, as in the closing scenes of any fatal illness, it is idle to expect anything from treatment, as of course we all know death really is the result of the failure of the *vis medicatrix naturae*."

At the eighty-second annual meeting of the British Medical Association in 1914, J. Arthur Thomson chose as the topic of his address, "Vis Medicatrix Naturae." He noted "the links between zoology and medicine are many and ancient," and went on:

> "What, then, do I mean tonight by the healing power of Nature? I mean to refer to the way in which Nature ministers to our minds, all more or less diseased by the rush and racket of civilization, and helps to steady and enrich our lives." The rest of his speech spelled out ways and means whereby one might heal and strengthen his mind by noticing, and thus keeping alive in himself, the grandeur, beauty, interest, order, and harmony of his world.
>
> "Alas! that the profession in the succeeding centuries should have fallen so far from this simple doctrine," deplored Dr. Robert Dawson Rudolf, tracing the tenet and profession of self-heal to the Father of Medicine (Contributions to Medical and Biological Research, 1919). Dr. Rudolf safely and sanely observed further, "There are, from the patient's viewpoint, both good and bad forces of nature; it is only the former that constitute the *vis medicatrix naturae*."

Freud, whose unique contribution to human health was the means whereby an individual might become aware of his *vis medicatrix naturae* (the "psychoanalytic method"), also conceived of a human instinct to live (carried by a life force, the *libido*) and of a death instinct. Every individual's health vicissitudes are

brought about by his own living and can only be cured by his own living.

Cicero considered "cultivation of the mind to be a kind of food supplied for the soul of man." Certainly, my experience has demonstrated to me that cultivation of my mindfulness, itself, so that I can realize and appreciate my mental powers, has been most rewarding exertion. I can and must say Yea to (my) Shakespeare's positive note, "For 'tis the mind that makes the body rich." And, as Lao-Tse observed, the sage "makes the mind of the people his mind."

The truth is that every human being has nothing whatsoever to rely upon except what he can accomplish by means of his own life. Everything in his mind is the creation of his life process, it is himself. He uses his mind as an instrument for developing his medical self-experience which will promote his maintenance, or recovery, of his optimal health. Paracelsus held every man to be his own doctor, claiming, "the physician is in ourselves, in our own nature are all things that we need." His treatment of wounds was "defensive so that no contingency from without could hinder Nature in her work." And Sir Thomas Browne saw his medical self, "Things cannot get out of their natures, or be or not be in despite of their constitutions."

To sum up this section on historical references to *vis medicatrix naturae*, the "healing instinct" is the sole property of each single one. Everyone needs all of his "healing instinct" in order to care for himself adequately. If I can not see my life as all about *me*, it is an expression of my "healing instinct" when I begin to complain bitterly of not knowing "what life is all about." And this may be the experience of many a physician who has weakened his sense of personal identity by his *unrecognized study and practice of himself* in medicine. It is just as therapeutic for me in the role of physician to see myself extended to include my patient, as it is for me in the role of patient to see myself extended to include my physician. My laboratory studies and my bedside experience are of greatest medical use to me to the extent that I observe them as my efforts to cultivate my medical helpfulness, and do not confuse them with my patient's efforts to cultivate his medical helpfulness. Declared William Gull, "The law of health is the law of life. This is not truism, but a law."

Vis Medicatrix Naturae Works

> Body and soul are not two substances but one. They are man becoming aware of himself in two different ways.
>
> Von Weizsacker

The human system is the only possible system of therapeutics. Dissatisfaction with the idea that a man's health power is "external" to him is hardly limited to the self-sufficient radical individualist. "Medical treatment" of the patient consists of his activating his internal sanative powers and helping himself with the specific medical experience (of his very own) commonly known as "calling in his physician." The scare-head "professional isolationism" is always a generalization, but it can serve as a warning about the health risks implicit in the "doctor-patient" schism.

The force of mind in all therapeutics is becoming recognized, especially by medical leaders, and health disturbances traceable to mental dissociation are becoming of increasing sanatory concern. The scattering of a human being's health forces so that they do not lend themselves to ready mobilization in time of need, poses the greatest health problem possible. Giving a Hunterian dinner speech, Rudyard Kipling offered that the god Brahm had hidden the mystery of man in his own body. Of everyone's latent medical power, Sir Frederick W. Mott in 1923 stated, "Our aim as doctors should be to assist Nature's defences as far as possible, to study the advances in the knowledge of the physiological action of drugs, and the physiology of the human body."

I find it helpful to define disease (illness, or accident) as a health struggle, as a health ordeal. There is no doubt limited helpfulness in personifying the vicissitudes of human life under the names of "disease entities," but in my opinion it is far outweighed by the disadvantages of viewing heroic health struggles as hostile attacks. I can cure myself by helping myself with my medication. What a medical advance over my saying, "Drugs can cure me!"

Every person has great power, but nearly everyone has much of it in a disowned (unconscious) sense, as far as his owned (conscious) self is concerned. Thus he lives huge amounts of his might only as though it could belong to "someone else" (such as a parent, teacher, physician, clergyman, and so on). This displacement of his own manpower dislocates it so that he cannot use it at will. Such a partition of his potency is the result of his dissociating his mental strength into two great divisions: his "I" and his "Not-I". All of his self forces which are marshalled under his "Not-I" partition are no longer available for his volitional use. Furthermore, (a health factor of enormous consequence) from the operation of the forces of his "Not-I" partition, he cannot develop his sense of self-esteem, but rather must develop a sense of esteem for (his own) unrecognized "authority."

Without the aid of my proper sense of self-esteem, I lack the proper motivation for taking proper care of myself! In the 18th century, Rabbi Shmelke distinctified "Not-I" living as being the product of self-unawareness: "It may sometimes happen that thine own hand inadvertently strikes thee. Would thou take a stick and chastise thy hand for its heedlessness, and thus add to thy pain? It is the same when thy neighbor does thee harm: shouldst thou retaliate, it would be thou who wouldst suffer."

Everyone's *conscious* employment of his mental power as his therapeutic agent, provides him with the most efficacious way of life. Most of all, it is essential that the medical student growing his doctorhood create for himself a self-image which will permit him to see that comprehensive medicine consists of "the whole physician for the whole physician" and of "the whole patient for the whole patient." Said Lao-Tse, "There is nothing like keeping the inner man. The sage embraces unity."

There is no more potent health force, including remedy, than the will (wish) to help one's self. St. John Chrysostom eternalized this truth, "Grace cannot do anything without (human) will, nor will anything without grace." This will (wish) to live is itself a medical force worthy of most careful investigation. Thus, I may be conscious of the will to restore my balance of health; however, I may be unconscious of my will to end my life. My interest in living, to the extent that it exists, is most favorable to my prognosis. In the *British Medical Journal* of 1889, Sir James Crichton Browne reported, "The general medical practitioner has to have regard to the psychological condition out of which corporeal diseases grow, and by which their course may be beneficially or injuriously affected." Particularly is this medical viewpoint applicable to the status of the patient's will (wish) to live. All of the therapeutic value of hope (encouraging self-dependence) lies in the direction of this will (wish) to help oneself. The most helpful patient is the one who becomes most adept in applying the truth that only he can heal himself, that only he can augment his healing power by willfully enriching his medical self-knowledge (by consciously cultivating his healing and strengthening self-experiences).

As a patient, the strength of my conscious will varies with the extent of my self-consciousness. Only the power which I can consciously call my own is accessible for my voluntary use. Thus, I may be troubling myself very much with the thought and feeling that I want to die. Therefore, I may be only able to be aware of my wish to end my life. The fact that such a view of the worthlessness of my living has this obsessive force is an indication that I have not been willing to consider such a view as being an entirely natural one. Once I can live my death thoughts kindly and see each and every one of them as a natural part of my human nature, then I free my mind for attending to self views which are favorable to my going on living me.

One of my friends once had considerable trouble with his idea and feeling of "wanting to die." When I observed that I found such a thought and feeling to be a natural one in my own life, he calmed himself, and observed, "Please say *that* to these folks around here, for they have been telling me that I ought not have such a thought, or feeling." My nature is marvelously made, and it takes great courage for me to let myself be aware of much of it. Recorded William Harvey, "*Nature* herselfe must be our adviser; the path she chalks must be our walk."

The "gift of healing" is not transferable. The personal presence of the physician is therapeutic exactly to the extent that his own presence of mind is consciously secure. Even though he recognizes that his patient may be momentarily (temporarily or indefinitely) incapable of *consciousness* of his own independence, of his own inviolable individuality, of his own wonderful manpower—nevertheless, it is absolutely indicated that the physician see and duly appreciate the fact that his patient does have all of these human powers. Said Mencius (B.C. 313), "Humanity is the heart of man; justice is the path of man. To know heaven is to develop the principle of our higher nature."

Knowledge of human nature occurs in no form but self-knowledge. Adolf Meyer heeded the practicality of obedient regard for this locating of mental forces *in* the individual: "We must turn to where vital things happen, where they have their beginnings and developments." Medical tact is the product of the physician's being in touch with himself, renouncing the illusion that he can be in touch with some world other than his own. His consciously sound mind, which unifies and frees his manpower for use, is indispensable for his seeing what it is that his patient needs most to learn about *his* self, what self-treatment the patient is needing to enforce for *his* self. It is here where the practical wisdom of the medical man is tested. How insightful was Manu, the idealistic Hindu lawgiver (1200 B.C.), "Intellect repeats the work of creation."

Any neglect of mine of the *vis medicatrix naturae* of my patient is a neglect of the manpower needed for

his recovery. This manpower is entirely unconscious in its operation. Elements of it may be momentarily associated with self-consciousness. A chief value of my patient's self-consciousness is that through it, and only through it, he will cultivate new appreciation of the worth of his life, *an appreciation which is the greatest hygienic power he has.*

Much of the traditional meaning of diagnosis to the contrary, there is no way in which I can either understand or misunderstand my patient. I do have a greater ability than that, in having my patient understand himself and misunderstand himself. What passes for "understanding of my patient" is my living of my patient with no feeling that my sense of self-understanding is impaired. All of my misunderstanding must be cleared up by my seeking out the self-experiences which I need in order to live myself as understandable. If I indulge my illusion that I can agree with "somebody else," I unwittingly let myself in for suffering the illusion that I can disagree with "somebody else." Full appreciation of the health potentialities of my patient's mind includes all of the alleviations of his suffering which he can effect by means of his physical and chemical (self) experiences.

Strongly established and time-honored traditions in medicine are "the self-sacrificing physician" and "the grateful patient." Insights that a physician's self-devotion is compatible with his medical work, and that a physician regards his patient's gratefulness to *his* self only as medical progress, are fortunately becoming less and less rare. It is too much to expect one's patient to have this degree of medical insight, but it is only proper to expect one's self as a life-long medical student to explore the full health significance of self-heal. However, the question still remains whether or not medicine shall declare itself openly a science of self-help. "Let us open our eyes, lest they be painfully opened for us." (Turkish proverb)

Summary

A man's own observation, what he finds good of, and what he finds hurt of; is the best physic to preserve health.

Bacon

Hippocrates asked his fellow physician to consider the practicality in treating his own life well, noting that "the public believes that those who do not know how to take care of their own bodies are not in a position to think about the care of others." As a medical man, it is my duty and privilege, but above all, my personal health need, to live my medical world *consciously* as my own. My vaccines increase my active immunity; my antitoxins provide my passive immunity; my over-exertion of one of my organs compensates for reduced function of another of my organs; my splint augments my sense of my pain's usefulness in immobilizing my injured and knitting tissue; my surgical operation eradicates dangers to my life; and so on. Thus, all of his medical experience is lived personally by my patient also. Indeed, the only reality in my medicine is myself; and the only reality in my patient's medicine is (my) he. There can be no more and no less medicine than the one who lives it.

Fortunately, every physician helps himself in his very own unique way. He can build his medical character safely only upon this self-reliant way of life. He will add to his medical competence when he is entirely ready to do so. My personal experience in avoiding the pains of extending my self-awareness bears out the truth in Horace's satire: "A mind that is charmed by false appearances refuses better things." Horace's epistle also fits my case: "If anything affects your eye, you hasten to have it removed; if anything affects your mind, you postpone the cure for a year." All of my power of resistance, pending my *willing* my extending my self-awareness, is a precious potion of my *vis medicatrix naturae.* Indian piety exalts this view, "Let a man raise himself by his Self, let him never lower himself; for he alone is the friend of himself and he alone is the enemy of himself" (*The Blessed Lord's Song,* Srimad-Bhagavad-Gita).

Teachers of physiology are now giving heed to the wisdom that presides in and around the various systems of the body. "Pathological findings" are becoming recognizable as drastic therapeutic efforts of the body tissues, as the body's acting on its own initiative to secure relief. Clinical signs and symptoms are being credited as the therapeutic efforts which they always are. Every aspect of the patient's behavior is now being wholesomely appreciated (by his physician) as his best available efforts at self-help. Voltaire's dictum, that doctors pour medicines of which they know little into bodies of which they know less, applies less and less.

The apt expression "dry clinic" is realistically applicable to bed-side medicine if the doctor does not live his patient as his own self-experience. Again, fully comprehensive medicine advances this orientation: the whole doctor for all of his living; and the whole patient for all of his living. Motse described his way of universal love, "It is to regard the state of others as one's own, the houses of others as one's own; the persons of others as one's self."

I help myself by making peace with whatever illness (or accident) I may be suffering. My health trouble is saying something which I need to study and

(Continued on Page 51)

A Semmelweis Phantasy

Prologue for a Biography *

Irving I. Edgar, M.A., M.D.
Detroit, Michigan

I

WAS IT DREAM? Was it phantasy? Was it reverie in Mussorgskian Bare Mountains? I stand before the monument to Ignatz Philipp Semmelweis in reverent contemplation. What heights of suffering that man experienced! What depths of despair! There on a rounded pedestal of marble he stands—erect with sad and brooding face; at times full of mad defiance; at times changing into wistful appeal. There is a far-off look in his eyes—a hopeful visionary stare into the future. Little winged cherubs play about his feet drawing wreaths, and a mother sits by, holding a baby in her arms. Her eyes look up at Semmelweis, and they are the eyes of gratitude—motherhood showing gratitude. . . .

The senses dull into distance. The fancy flows. A tragi-comedy will soon be enacted here. It is the dead of night. The sky is heavy with blackness. Autumn winds go moaning through the trees scattering dry leaves before them—making earth barren. The mood is set. . . .

Out of the darkness, strange murmurings arise, swelling in waves into a chaos of voices. Shrieks of terror rend the air. Agonized laughter. And women wrung in the throes of pain, rent asunder on the rack of Labor. Newborn children are whining. Macbethian witches are dancing round and round in fiendish glee—uttering raucous jabberings to the tumult. Cries are lacerating deeply into the night:

"Ho, Jesus Christus! Mercy upon us."
"O God, Let us die."
"Santa Maria, Save us!"

Presently, there is a leaden silence, broken occasionally by suppressed moanings or abandoned sighings. What is that foul odor filling the air and choking the atmosphere with death? That is the hospital stench. That is the stench of decomposing blood and lochia. That is the stench of rotting flesh, and of peritonitis, of cadaverous foulness.

Now there are peals of thunder and streaks of lightning. That statue of stone turns to life. The face of Semmelweis is illuminated by a pale lunar light; and tears are dropping from his eyes. The expression



International monument to Semmelweis.

changes now and then, from that of pain to that of explosive anger; from that of compassion to that of stoic acceptance. The tumult swells again. And back and forth a strange march begins like some ghostly procession out of Shakespeare. Shapes begin to form themselves, becoming clearer and clearer.

There you have a pyramid of half-dissected cadavers with stray limbs and skulls and hearts about.

*See Edgar, Irving I.: Ignatz Philipp Semmelweiss, *Ann. Med. Hist.*, 1:74-96 (Jan.) 1939.

And nearby are rows of beds filled with women in childbirth torment, two and three and four to a bed. And the bedding is heavy with filth. And the air is laden with a privy stench. And the floor is a pool of jellying blood. See! Crowds of students are dipping their hands into greasy cadavers. And as they withdraw them, every finger is reeking and dripping with death. And these hands with these fingers they place upon the nearby women, until shieks of pain pass from their lips and cries of mercy. But in taunting answer, grotesque gnomish fiends appear, and with wooden mallets they pound and pound upon these women's abdomens. And the sound is that of low-pitched drums. The students laugh and jeer in derision.

A nurse and a surgeon are soaking dressings in a river of pus flowing from a knee. They pass from woman to woman, and from these dressings drops of pus are dripping into gaping wounds. And soon from these gaping wounds tiny rivulets of pus also begin to flow, swelling into the larger stream nearby.

Off to one side a woman is writhing in the agonies of labor. In the middle of the street, the child is born. And the mother raises up her voice, in prayer: "Thank God, my baby was born in the street rather than in the hospital, for I shall live to suckle it with my own breasts."

Darkness and silence. But soon it begins to stir again. Mourning church bells ring out at intervals and linger fadingly into the night. A procession of monks, carrying lighted candles, passes before us, intoning elegaic psalms. Poor dying souls. This procession is the procession of the last Sacrament!

And there stands Semmelweis. He covers his face with his hands and his grief is drowned in convulsive sobs. But look! Is not that Koletchka passing by dressed in the shroud of death?

Now comes Hebra and Rokitansky and Skoda. They are shedding tears; and these turn to blood before they reach the ground. They are soon followed by Scanzoni and von Kiwich and Carl Braun carrying decapitator hooks. They point at Semmelweis in jeers and laughter. And from every pointing finger, sharp arrows dart into the flesh of Semmelweis, who tears around in goaded rancor like some bull maddened in a Spanish arena until, exhausted, he sinks to the ground, all the time laughing an insane laughter. . . .

A chorus of voices are shouting:

"Du 'Pester Narr."

II

A man is standing on top of a windblown hill. That is Semmelweis. Below is Europe. Semmelweis gazes all around him as far as he can see. There looms up Vienna, and Budapest, and Prague, and Paris, and Copenhagen, and Strasbourg, and Munich. And their streets are filled with dead and dying mothers, and wailing orphaned children.

From out the centers of these cities, a smoke arises blanketing the valley of Europe and enwrapping the hill where Semmelweis stands in heavy mist, choking him with the stench of child-bed fever. And the air becomes filled with the din of metallic noises: 10 per cent mortality! 15 per cent mortality! 20 per cent mortality! Close all hospitals!

Through the mist, the eyes of Semmelweis flare up in arrows of flame. In one hand, he seizes a flask of chloride of lime, and with the other hand, he sprinkles it at the valley of Europe below and around him. Miracle of miracles! The mist, and smoke, and stench disappear. The cleansing chlorine fills the air. . . . But only for a moment. The smoke and stench rise again in greater intensity. A mob of men march upon Semmelweis and throw the flask of chloride of lime from his hands. Semmelweis pleads, exhorts, and threatens. And in final rage, he shouts, "You munderers of puerperal women. You dare defy the eternally true etiology of child-bed fever!" But voices thunder back; in deafening echoes,

"Atmospheric, telluric influences."

Quiet reigns now. Semmelweis raises up his eyes to heaven in supplication. The moments pass. . . . A man trudges up the hill towards Semmelweis. It is Michaelis of Kiel. His hair is disheveled and his eyes have a wild stare in them as of a hunted animal. As he reaches the top of the hill, he plunges a knife into his breast shouting to Semmelweis: "The ghost of puerperal women shall no longer torture my soul."

Semmelweis weeps and soon becomes like a man possessed—eyes flashing, mouth frothing, face reddened with anger. He shouts into the void about him:

"You professors of the great Universities and hospitals, you physicians of medicine, you doctors of midwifery, your



The Author

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schools are schools of lies! Your hospitals are filled with the dead and the dying from the child-bed fever! The slaughter proceeds in shameless numbers! The mortality rates shout to very heavens! You are the sowers of the seeds of death! You are the executioners of puerperal women!—grim reapers in the guise of benevolence. You stand accused by orphaned children! History will write you down as medical Neros!"

An harangue of diabolic voices fills the air, engulfing the voice of Semmelweis. And the voices are shouting:

"Du 'Pester Narr."

III

A bare steep room of four grey walls and no door. Just a small barred window placed high up relieves the monotony of barrenness. And through this window, a large beam of sunlight cuts sharply into the room. It illuminates the face of a man into grotesque outlines of lights and shadows, and deep furrows, accentuated into bold relief. The muscles are tense with determination. But the eyes appear so sad, so tired—dulled by nights of sleeplessness—weary with days of writing. Even now, this man is sitting at a table piled high with books, and magazines, and papers in careless disorder. And he is writing furiously page after page. Can that be Semmelweis? But how changed in aspect!

Presently he stops. Hands fall to his sides in sheer fatigue. The body becomes bent and slumps forward. Only the face remains tense. He rises and speaks with fanatic fervor: "I have answered them all. I have given them of the bitterness of my heart. Yet the hurt still rages within me." He paces the floor to and fro and then stops, directly in the path of sunlight pouring down from the window. And his face lightens with prophetic zeal as though motivated by some inner force. He stretches out his hands to heaven and speaks:

"Have I not given them the true etiology of child-bed fever? Have I not labored for my doctrine for twenty years. . . . Twenty years. . . . But are the hospitals free of puerperal stench? Are the schools free of lies? Are the deaths decreasing? Has the slaughter of innocents ceased?"

He goes to the table and picks up a new book on midwifery, turning the pages at random. He stops. His attention is focused to the heading of a chapter. He reads:

THE CAUSES OF CHILD-BED FEVER

Child-bed fever has many causes. They may be divided into two main divisions: first, the external factors, and second, the internal factors. The external factors may be summed up in the phrase, "atmospheric, telluric influences." And these include the influence of climate, season of year. . . .

Semmelweis can hardly believe his eyes. He stares as though in a daze. He reads further on:

In 1846, Semmelweis propounded the theory that child-bed fever was due to cadaveric poisoning introduced into puerperal women by student's examining fingers. . . . He introduced chloride of lime as a handwash. . . . This theory, however, has long been disproved and has passed into rightful oblivion.

Theory . . . Disproved . . . Oblivion . . . The words pass the lips of Semmelweis showly, mechanically. Then they hurl themselves at him from every direction. They burn into his mind with tongues of flame. They roar in his ears with claps of thunder. They sear into his eyes in gobs of molten metal.

The storm breaks in the heart of Semmelweis and flows over in breakers of anger and torrents of words. He rushes at the table and with a sweep of the hands throws everything to the floor. He rages at the books. He tears at his clothes. He beats at the four walls. Until exhausted and bleeding, he sinks to the ground.

Silence. A weird twilight fills the room. The wailing of women ebbs and flows in waves. Unearthly shrieks split the air. A riot of discordant voices are jeering:

"Du 'Pester Narr
Du 'Pester Narr
Du 'Pester Narr"

Go by, ungrateful world. Go by.

Vis Medicatrix Naturae

(Continued from Page 48)

understand. It is of limited helpfulness for me to be attacking myself under the alibi of "Illness" or "Accident."

Similarly, it is clinical insight for me to be able to grow views of my patient and see nothing but my patient, to be able to observe that my patient includes *his* illness or *his* accident, to note that my patient is not divided against himself. It is safe and sane for me to study my micro-organism (or virus) without confusing it with my patient and my patient with it.

How challenging, Descartes! "If there is any possible means of increasing the common wisdom and ability of mankind, it must be sought in medicine;" and, as an English proverb asserts, "Let every man praise the bridge that carries him over."

Mencius said:

"When Yi (a famous archer) taught people to shoot, he told them to pull the string on the bow its full length. The man who wants to cultivate himself must also develop himself to the full extent. A great carpenter teaches his apprentice to use squares and compasses. The man who wants to cultivate himself, must also have squares and compasses for his conduct."

Current Concepts and Treatment of Incompetent Internal Cervical Os

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MISCARRIAGE or sponaneous abortion during the mid-trimester of pregnancy has occurred since the beginning of time, but not until recent years has one etiologic factor received recognition as a clinical entity. Much time and effort have been focused upon the treatment of threatened abortion in the first trimester with the various bioflavonoid products, wheat germ oil and various combinations of estrogens and progesterones, but it is doubtful that these have played a role in the prevention of incompetency of the internal cervical os in pregnancy.

Abortion between the fourteenth and thirtieth week of pregnancy may be associated with an otherwise normal conceptus and does not appear to be benefited by use of the medications named above. Almost without exception, the patient has felt fetal movement by this time. This is in contradistinction to abortion during the first trimester when it is presumed that approximately 50 per cent of the losses are due to the so-called "blighted ovum," and without exception the patient has not noted quickening. At present, there appears little we can do to prevent this condition, but the situation is quite different for the mid-trimester abortion group, since the etiologic factor is commonly based on a maternal defect rather than on a fetal abnormality. The incompetent internal cervical os is now recognized as an important cause of habitual mid-trimester or late abortion and by definition suggests the inability of the cervix to retain an otherwise normal pregnancy to the stage of viability. It is believed this incompetency is the result of an anatomic defect in the cervix proper, but endocrinologic and neuromuscular changes cannot be excluded as participating or causative factors in some instances. Premature separation of the placenta and other bleeding complications with resultant cervical dilatation must also be considered.

As a rule, there are no premonitory symptoms of cervical incompetency until unexpected painless and causeless rupture of the membranes occurs. This is generally followed by a short, easy labor. Since this condition is seldom recognized in a first pregnancy, trauma must be considered a possible cause. Study of case records suggests that the defect may be a result of previous overzealous dilatation and curettage, criminal abortion or a precipitous or traumatic term delivery. Procedures such as Duhrssen's incisions and amputation of the cervix must also be considered. A congenital weakness of the cervix has also been suggested.

Diagnosis

A diagnosis of incompetent internal cervical os is strongly suggested or confirmed (1) by obtaining a classical history of previous spontaneous interruption of pregnancy during the middle trimester, (2) by demonstrating the anatomic defect in the non-pregnant state, and (3) by visualizing the characteristic changes on speculum and/or digital examination during pregnancy. A high index of suspicion should be aroused when a patient presents a history of repeated mid-trimester pregnancy loss following spontaneous rupture of the membranes and delivery without intercurrent term delivery. Such suspicion is strengthened if the patient has previously delivered viable infants, and a history of possible trauma to the cervix as indicated above is also supporting evidence.

In the nonpregnant state, the anatomic defect may be demonstrated by radiographic technique. Rubovits, in 1953, described the intrauterine balloon technique. He inserted into the uterine cavity a small balloon attached to a cannula after which a measured amount of radiopaque substance was introduced. X-rays, taken before and after traction was applied to this system, permitted visualization of the cervicouterine angle and the area of the internal cervical os. Others have inserted a Foley bag catheter into the uterine cavity and then injected radiopaque material as for routine hysterosalpingogram. The injected media outlines the inflated Foley bag which may demonstrate competency or incompetency of the internal cervical os. Despite the minimal gonadal exposure to radiation, some examiners prefer to utilize a nonradiographic test in diagnosing this defect. Hegar dilators are some-

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times employed to determine cervical incompetency which may be suspected when a No. 8 or larger Hegar dilator passes through the internal cervical os without resistance. It must be remembered, however, that none of these techniques is sufficiently accurate to afford complete dependability. Obviously, none of these techniques is to be used for diagnosis of cervix incompetency in the pregnant patient.

When cervical incompetency is suspected during pregnancy, the patient should be seen at weekly intervals and a speculum and/or digital examination of the cervix should be carried out after the patient has completed the first trimester. Cervical effacement with dilatation to 2 or 3 cm. revealing a bulge of membranes represent the classical findings at this presymptomatic stage.

Treatment

In 1950, Lash reported on the repair of the incompetent internal cervical os in the nonpregnant state. His anatomic restoration of the incompetent cervix in the nonpregnant patient by surgical means appears to have much in its favor. Lash first applied the pleating technique to the thinned-out anterior portion of the cervix at the level of the internal os. Later, he recommended excision of an elliptical segment of cervical tissue without destroying the continuity of the external cervical os. More recently, he has suggested that a segment of cervical tissue, approximately 2 cm. wide and 3 to 4 cm. long, be excised from the anterior cervical lip up to and including the level of the cervicouterine junction. He states that anatomically, one-half of the circumference of the cervical canal must be surgically removed to reduce the diameter of the cervical canal one-half; the diameter will vary directly as its circumference. In all three types of repair, a transverse incision is made in the anterior vaginal wall near its junction with the cervix. The anterior vaginal wall and bladder are then dissected upward to the region of the peritoneal reflection or to a point above the level of the cervicouterine junction. Generally, catgut sutures are chosen for the repair, but tantalum wire has also been used. The Lash operation has the advantage of being an elective procedure and is carried out in the nonpregnant patient after a careful clinical workup. Such patients may be ambulatory during pregnancy and are preferably delivered vaginally but have also been delivered by caesarean section. The operation may be a vascular procedure, and there is a small but significant incidence of failure which necessitates repeating the procedure or substituting some other form of therapy, if pregnancy is to have a successful termination. Unassociated infertility following the Lash procedure has been reported.

In 1955, Shirodkar in Bombay, India, reported on his technique for surgical closure of the incompetent cervix in both the pregnant and nonpregnant state, using homologous or heterologous fascia. These reports led others to investigate this clinical entity further and, in 1958, Barter, Dusbadek, Riva and Parks published their experience with the Shirodkar procedure at the George Washington University Hospital and the Walter Reed Army Medical Center. They, too, believe that careful selection of patients is extremely important since the procedures mentioned may otherwise be overused and abused. A history of repeated mid-trimester abortion following a sudden gush of amniotic fluid with subsequent delivery of a nonviable infant appears to be pathognomonic of this syndrome.

The technique devised by Shirodkar and introduced by Barter et al in the United States has as its aim the restoration of cervical competency during pregnancy by means of a purse-string suture. Various suture materials have been used, such as ox fascia, nylon, polyethylene tubing, fascia lata, and braided silk. At present, a synthetic Dacron tape (Mersilene*), measuring 3 to 5 mm. in width, is generally favored. This material was originally developed for use as a prosthesis for vascular surgery. After the criteria for diagnosis are met and operation decided upon, the patient is strictly confined to bed and prepared by the administration of one of the longer acting progesterone compounds for about twenty-four to forty-eight hours prior to surgery. This time factor may help rule out an abortion already in progress. At the time of surgery, a transverse incision (1.5 to 2 cm.) is made through the vaginal mucous membrane at the anterior and posterior cervicovaginal junction at the level of the internal cervical os. The anterior vaginal mucosa and bladder are dissected upward. A submucosal channel is then dissected on either side of the cervix joining the anterior and posterior vaginal incisions. The Dacron tape is placed around the cervix submucosally by means of a Gallie fascial needle. Transfixing sutures of No. 00 silk are used to secure the posterior portion of the tape at the level of the internal cervical os. The tape is then tied anteriorly (the reverse is also acceptable), effecting a closure of the internal cervical os with reduction of the herniated bag of waters. The mucosal incisions are then closed in a routine manner. The patient is

*Produced by Ethicon, Inc., Somerville, New Jersey.

placed on local antibiotic therapy and strictly confined to bed for about seven days, after which a program of limited activity is permitted. The use of hormones to reduce uterine irritability is recommended by some.

It is generally believed that the earlier in pregnancy the incompetent cervix is recognized and treated, the better the results are likely to be. This means the cervix should be closed between the fourteenth to sixteenth week of gestation, when the past medical history alone supports the indication for surgical intervention. Otherwise, one must await the presence of the classical findings associated with this clinical entity before subjecting the patient to surgical correction.

The Shirodkar procedure is not difficult to perform and generally little bleeding is encountered. According to most authors, the success rate is between 75 per cent to 80 per cent when it is employed in cases with early dilatation of the cervix and when no other complications exist such as mid-trimester uterine bleeding. Following surgery, the patient should be strictly confined to bed for approximately one week and then on limited activity for the remainder of the pregnancy. If use of the Dacron tape has successfully restored the competency of the cervix, the tape may remain undisturbed. The patient should then be delivered by caesarean section at the thirty-eighth or thirty-ninth week of pregnancy. Should she go into labor before the fetus is viable, the tape is transected and the patient allowed to deliver vaginally.

Comments

Incompetency of the internal cervical os appears well established as an important cause of late habitual abortion. This clinical entity is characterized by early rupture of the membranes followed by the spontaneous onset of labor and delivery usually between the fourteenth to the thirtieth week of pregnancy. A posttraumatic anatomic defect located at the level of the internal cervical os or a congenital abnormality are prominently considered as etiologic factors.

Recognition of cervix incompetency as a cause of abortion and the development of remedial measures represent an advance in our thinking and has been a boon to patients reporting repeated mid-trimester pregnancy losses. This recognition should increase the salvage rate of pregnancies formerly lost because of this condition.

As time goes on, the Shirodkar procedure is likely to find increasing application, since the inclusion of periodic examination of the cervix during pregnancy as part of the prenatal care will lead to more frequent diagnosis of the condition during, rather than after, pregnancy, and active steps may be taken to preserve the existing fetus. On the other hand, surgical closure on occasion may not be necessary, since the cervix may retain its competency throughout the pregnancy. In this connection, the overall statistics reported by Malpas are of interest. They indicate that 27 per cent of pregnancies occurring after three or more consecutive abortions continue on to term without the need for any specific therapy. Unfortunately, in order to justify surgical repair during the nonpregnant state, the patient should have experienced more than one fetal loss during the middle trimester.

It is also important that physicians do not become overenthusiastic in the use of either of these procedures. Surgery is not indicated when *only* slight cervical dilation is encountered, and clinical past histories of cervical incompetency must be well documented. Term deliveries have resulted for patients having a small amount of cervical dilatation without effacement or bulge of membranes many weeks prior to the onset of labor.

The past obstetric history, as it pertains to previous abortions, must be thorough and exact for there are many chances for error. For example, an early abortus may be retained *in utero* as a missed abortion, only to be expelled sometime during the mid-trimester, thus giving a history suggesting cervical incompetency. Knowledge of amount of uterine enlargement and presence or absence of quickening would be helpful in ascertaining type of abortion.

A particularly ominous sign in this group of patients is bleeding, which cannot be categorized as merely a "bloody show." When one encounters blood loss suggesting marginal sinus rupture, abruptio placenta or placenta previa in addition to the usual signs and symptoms of cervical incompetency, then caution should be exercised. Closure of the internal cervical os under these circumstances not only leads to failure, but probably places "the cart before the horse." The dilatation and effacement of the cervix may be the result of uterine irritability associated with the premature separation of the placenta and imminent onset of labor. In any event, caution is warranted, and the prognosis must be guarded!

Two operative procedures have been added to our obstetrical armamentarium for the treatment of cervical incompetency. Stress must be placed on accurate evaluation with all criteria strictly met before surgery is undertaken. Only by so doing will a higher salvage rate be achieved.

(Bibliography on Request)

The Doctor and the Public

Circa The American Revolution

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WHEN the lay public nostalgically asks for the whereabouts of the doctor of yesteryear, they conjure visions of a most saintly if not improbable fellow. He was kindly, unhurried, dedicated and altruistic. He was the town hero; a shield against the evils that plagued mankind. He had no thoughts of worldly goods, and his time was the exclusive property of his patients. In contrast (implied or direct), the present-day physician is not only berated by the lay press but, with increasing frequency, within his own profession for abandoning (less kind words can be substituted) the wonderful heritage which should belong to those who practice medicine.

To the many who enjoy the study of medical history, it is not a surprise that the physician of yesteryear was no less human than his counterpart today and that few of the problems and criticisms that plague us now were any less in his day. Indeed, he faced many more. It should be remembered that America was basically agrarian in the 18th and 19th centuries. Communities were small, and competition between the individual physician and between physicians as a group and the hordes of quacks was extremely fierce. Little that the physician said or did could escape the close scrutiny of the neighbors or townspeople. He had pitifully little of any scientific value to offer his patients. In truth, the patient of yesteryear, were he so unfortunate as not to have medical help, was usually much more fortunate than he thought. Opinions were also expressed more openly and in such vitriolic language that present-day criticism is "weak tea" in comparison.

If we were to choose any one man to be called "Mr. Physician" of American Medicine at the time of the Revolutionary War, he certainly would be Dr. Benjamin Rush; physician, teacher and patriot. Few are privileged to enjoy the prestige and fame that Dr. Rush did in his lifetime. Born in 1745 near Philadelphia, he received an excellent education, including the study of the classics, and graduated from Princeton with a Bachelor of Arts degree at the age of fifteen. He spent six years with Dr. Redman of Philadelphia in the study of medicine and then two years in Edinburgh, graduating from that medical school.

His medical life was very rich. He was one of the founders of the College of Physicians at Philadelphia and was Professor of Chemistry, held the Chair of the Theory and Practice of Medicine and the Chair of Practice. His political life was also exciting. He was a member of the Provincial Conference of Pennsylvania and served on the committee to consider and report upon the question of the expediency of the Declaration of Independence. Much of that report was incorporated into the Declaration. He subsequently became a member of the Continental Congress and became one of the signers of the Declaration of Independence. He was Port Physician in 1790, a member of the Convention of Pennsylvania for the adoption of the Federal Constitution in 1787, and Treasurer of the United States Mint in 1799 by appointment of President John Adams.

He enjoyed teaching and was a very prolific writer on many subjects. One facet of his writings and lectures was the problems of the physician in his relationship to the community, to his patient and to his fellow practitioner. This was so much more of an important phase of medical life than it is today that a part of the student's training was devoted exclusively to this subject. Some of the lectures that Dr. Rush delivered to the medical students bear the following titles: *On the Vices and Virtues of Physicians; On the Pains and Pleasures of a Medical Life; On the Means*

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of Acquiring Business, and Causes which Prevent the Acquisition, and Occasion the Loss of It, in the Profession of Medicine.

The following excerpts are taken from these and other lectures that are not only interesting in themselves but illustrative of the many problems of the time. As Dr. Rush was a very systematic and methodical person, they are quoted under his own subtitles.

PUBLIC INGRATITUDE

. . . In the month of December 1793, the citizens of Philadelphia assembled at the statehouse, and voted their thanks to the committee who had superintended the city, during the prevalence of the fever that year. A motion was afterwards made to thank the physicians of the city for their services. This motion was not seconded.

THE DUTIES OF A PHYSICIAN

. . . establish yourself as soon as possible on the farm . . . it will reconcile the country people to the liberality and dignity of your profession, by shewing them that you assume no superiority over them from your education. . . .

. . . the benefits of a farm will furnish you with employment in the healthy seasons of the year, and thereby deliver you from the taedium vitae, or what is worse, from retreating to low or improper company. . . .

. . . the resources of a farm will prevent your cherishing, for a moment, an impious wish for the prevalence of sickness in your neighborhood.

THE ARTIFICIAL AND ACCIDENTAL MEANS OF ACQUIRING BUSINESS IN THE PROFESSION OF MEDICINE

Sir John Hawkins tells us he made it a practice, when his son was called out of church, always to pray publicly for the recovery of the patient he was sent for to visit. . . .

. . . singularity in behaviour, dress and diet. Great taciturnity, a sententious mode of conversing or the practice of nodding, instead of speaking in company, a large wig and gold headed cane, have all been the means of different countries of acquiring business. . . .

. . . several instances . . . impiety, profane cursing and swearing, drunkenness, and even the most public acknowledgments of infidelity, and atheism have contributed to introduce physicians into business. . . .

. . . great minuteness in inquiring into the symptoms of disease. The inspection of the lips and teeth by a magnifying glass, the tasting of the urine and sweats, the smelling of the faeces, and even getting into bed with sick people in order to discover the quality of perspirations, have all been practiced with success as the means of acquiring reputation and business in medicine. . . .

. . . trifling and absurd refinements in the prescriptions of medicine as to dose, manner of preparation. . . .

. . . an affection of a sudden and intuitive knowledge of a patient's case by feeling but a few strokes of his pulse, or by barely inspecting his countenance. . . .

. . . walking or riding without any definite object, particularly in rainy and stormy weather. . . .

. . . speaking in all companies of the number or rank of patients, or ordering a servant to remain with a carriage before the doors of persons of distinction who are not sick. This art has been practiced with success in the city of London. . . .

. . . an accidental cure, particularly of worms. . . .

. . . such is the credulity of mankind with respect to medicine, that a physician has sometimes gotten into business by the accidental circumstance of his being the seventh son.

THE DISHONORABLE METHODS OF ACQUIRING BUSINESS

. . . opposing the principles, and traducing the practice and characters, of brother physicians. . . .

. . . taking undue advantages of brother physicians in consultations. . . .

. . . publishing accounts of cases that never existed, and of cures that have never been performed. . . .

. . . charges so low as to allure patients from the old and habitual physicians.

THE UNJUST CAUSES OF THE LOSS OF BUSINESS

. . . the discovery and propagation of new principles, or of new modes of practice in medicine. To prove this remark, I need only mention that Dr. Harvey lost all his business after he published his account of the circulation of the blood; and that Dr. Sydenham was thrown into the background of his profession, after he introduced depleting medicine and cool air in the cure of inflammatory fevers . . .

. . . the early declaration of the existence of pestilential disease in a city or county. . . .

. . . making light of a disease. A physician in this city was sent for, to see a child a little indisposed from teething. He told the parents, that its disease was of a trifling nature, and that it would cure itself. The next day the physician called again to visit this child. Upon asking how it was, the mother told him, he had mistaken its disease; that her neighbors had told her it was a very dangerous one; and that she had sent for another physician, who was of their opinion; and that he had sent the child a medicine, which had, in a few hours, perfectly cured it. . . .

. . . the want of popular and engaging manners. It was this personal deficiency in Dr. Smellie, who possessed the first abilities and skill as a man-midwife, which prevented his rising above the second rank in business in the city of London; while Dr. Hunter, with fewer advantages from age and experience, soon occupied the first grade in the same profession. . . .

. . . communicating to patients the knowledge of the amount of their pecuniary obligations, or in other words, sending in their accounts, they create an irritating sense of obligation, which ripens by time into hostility. . . .

. . . writing poetry, and upon subjects unconnected with medicine. Dr. Darwin was so sensible of this incident that he did not commit his Botanic Garden to the press, until he was assured by several of his friends, that his age and the long establishment of his medical reputation placed him beyond the reach of the least injury. . . .

. . . however trifling and unjust the cause may appear, I have heard of a physician who lost the attendance upon two families in this city in consequence of the offensive noises made by his shoes in ascending the stairs, and entering the sick room.

THE VICES OF PHYSICIANS

... avarice ... a surgeon in the British Army, who made it a practice to take the swords of the officers, as a security for the future payment of his bills.

VEXATIONS OF MEDICAL LIFE

... the dependent state of physicians, upon public opinion for their subsistence. It is this which has checked innovation in the practice of medicine, and too often made the physicians the apothecaries of their patients....

... the extensive and profitable business, which sometimes falls to the share of those physicians who have been remarkably unsuccessful in their practice....

... equal vexation is the false judgment which the public forms of the characters of physicians....

... another source of vexation to a physician arises from an intolerant spirit in mankind....

... a dread of the expenses of medical services, has sometimes occasioned death from diseases that might have been cured....

... the neglect in patients to comply with the prescriptions of their physicians. Sir Richard Nash was once asked by his physician, if he had followed his prescription. "If I had," said Sir Richard, "I should certainly have broken my neck, for I threw it out of my window." ...

... it is because our profession is a degraded one, that gentlemen of other professions usurp the right of thinking for us upon political questions. The world does not treat the profession of the law with so much disrespect.

DUTIES OF THE PATIENTS TO THEIR PHYSICIANS

... a patient should never send for a consulting physician without the consent of his family physician....

... a patient should always send for his physician in the morning ... should avoid calling him unnecessarily from meals.

GOVERNMENT VEXATION

... "Governments which do not apply their stamp of approbation to subjects of luxury, until they have passed rigid inspection, should prohibit traders from circulating, with impunity, products upon which the health of the citizen so essentially depends." ...

... the interference of governments in prohibiting the use of certain remedies and enforcing the use of others by law....

... conferring exclusive privileges upon bodies of physicians, and forbidding men of equal talents and knowledge, under severe penalties from practicing medicine within certain districts of cities and countries.

In summarizing one of these lectures, Dr. Rush concludes with the following statement which is almost a lament:

... how great are the contradictions, and how capricious are the dispositions of the human mind in its relation to physicians. It would seem as if the apparent allotment of human affairs by "time and chance" applied in a peculiar manner to our profession; and that success in it were as much the effect of the latter, as a high prize in a lottery...

Radioisotopes Can Cure Disease

Radioisotopes are being used to treat cancer, leukemia, toxic thyroid goiter, angina pectoris, eye diseases and polycythemia vera. The latter is a disease of too many red blood cells, in contrast to anemia where there are too few red blood cells.

Writing in the December *New Physician*, official journal of the Student American Medical Association, Gould A. Andrews, M.D., of the Oak Ridge, Tennessee Institute of Nuclear Studies, states: "In the therapeutic use of radioisotopes, any benefit to be obtained must come from the destructive or damaging effects of radiation on tissues. ... In some situations the radioisotope treatment has unique value, while in others, equally good results can be obtained by conventional x-ray therapy or by chemotherapy."

The proper use of radioisotopes can substitute for the surgical removal of the thyroid.

Radioisotopes are also used to determine thyroid, liver, intestinal, and pancreatic function. They can help explain the mechanism of some anemias.

"Radioisotopes have made perhaps their greatest contribution in fundamental biological research," according to Dr. Andrews. "Here they are usually used as labels or tags for complicated organic molecules. The experiments in which they are used almost invariably involve also a variety of other laboratory procedures not using radioisotopes."

Evaluation of Drugs

H. D. Kautz, M.D.
Chicago, Illinois

THE PRESENTATION of this subject is motivated by the opportunity to discuss some of the important problems of drug evaluation from the point of view of the AMA Council on Drugs and to review various areas of responsibility in the development and use of new therapeutic agents. There is hardly any branch of modern science or society which is not in some way concerned with the basic study, clinical trial, pharmaceutical distribution and administration of drugs, including the dissemination of information concerning them. The medical investigator and educator, as well as the practicing physician, share with the manufacturer, the pharmacist, government regulatory agencies and other organizations, the responsibility for advancing scientific knowledge and the rational application of drugs. It is only through mutual cooperation and understanding of the problems in this area, that we can hope to exert maximum effort for progress in all of the changing disciplines of modern medicine.

Interpretation of Scientific Data

Of primary significance in the evaluation of drugs is the interpretation of reports of laboratory and clinical studies, whether this is done by the investigator or by others. Such terms as investigation, evaluation, appraisal, assessment, usually are applied to the actual conduct as well as the interpretation of experimental observations. It is strictly in the latter sense that the AMA Council on Drugs evaluates therapeutic agents, since it does not undertake to perform or supervise tests. Reports of investigators should, and usually do, include their own interpretation of results. There would seldom be any need for appraisal of scientific data by others, except to correlate information from different sources, if all reported studies were designed and interpreted by statistically sound methods. Until such an idealistic situation can be realized, there will be a continuing need for objective and critical analysis of reports by individuals, as well as by groups such as the Council on Drugs, who have not participated in the conduct of investigations. Appraisals of therapeutic studies by nonparticipating experts, are especially helpful to practicing physicians.

Actually, there are only a few general principles involved in the critical interpretation of scientific data. For example, in reading reports on therapy, one should look for satisfactory answers to certain fundamental questions. Are the observations which are recorded designed to eliminate possible bias of the observer and the influence of factors other than the drug, i.e., are there controls or randomization in the selection of treated patients? If not, is there a compelling limitation which might justify their exclusion? Obviously, in the study of therapy for serious and life-threatening illnesses, a comparison with entirely untreated controls may not be feasible. If controls have been included, are they designed to minimize or exclude significant variables? Is the condition for which therapy is studied one which is subject to spontaneous remission within the period of the observations, i.e., does the study take into account the natural course of the disease by including appropriately spaced follow-up examinations for evidence of recurrence? Thus, it can be seen that within certain limits, the validity of reports on new drugs may be judged by the care with which the observations are designed to provide comparisons with longer established methods of treatment. If no reasonable effort has been made to control or conduct observations in a manner which affords comparisons with no treatment, other forms of treatment, or the modality of the disease, conclusions respecting the results must be considered questionable.

Through its publications, the Council on Drugs seeks to provide objective information which will aid physicians in judging the current status of therapeutic



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Presented at the Michigan Clinical Institute, Detroit, March 10, 1960.

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agents. The Council's statements point out whenever applicable, the inadequacy of the available clinical evidence to support the proposed uses of drugs. Indeed, reports on the clinical use of new drugs are all too frequently based upon uncritical observations. Some of them amount to little more than a tabulation of subjective clinical impressions. Editors of medical journals can exert a greater influence for improvement in the quality of reports on therapy by rejecting for publication those papers which are based upon poorly designed studies. Except for reports of unusual cases, of unsuspected serious toxic reactions to drug therapy, or of new life-saving drugs for previously fatal diseases, physicians should resist the temptation to submit papers for publication which are not based upon carefully controlled observations. Publication of poorly conceived reports on drugs only swells the confusion which arises from the vastly expanding medical literature.

Magnitude and Quality of Research

The laboratory development and clinical trial of promising new chemicals for use as drugs is probably at an all time high in the United States. Industrial synthesis and testing of numerous chemical analogs and derivatives for unique and related pharmacologic properties, including the isolation of principles extracted from plant sources and the collection of soil-bearing microorganisms for distinctive antibiotic activity, has continued at an ever accelerated pace since World War II. As a consequence, the number of compounds selected for clinical study has rapidly outstripped the facilities for their careful clinical investigation. The shortage of facilities for clinical trials of new compounds involves the number and suitability of patients for study as well as the number of competent clinical investigators available to conduct them. Moreover, those clinicians who are capable of properly designing and carrying out objective human trials of new drugs, usually have teaching and other research obligations, which limit the time they can give to the study of industry-developed drugs. Indeed, human pharmacology has attained the status of a medical specialty for which expert knowledge and experience are essential. However, the desire of competently-staffed medical institutions to carry out their own research programs, has been coupled with a tendency to reject industry-proposed clinical trials of some new drugs. This has led drug manufacturers to place a large part of their clinical research in the hands of private phsicians, not all of whom are expert in this field. Under such circumstances, manufacturers supply investigational drugs to a large number of individual clinicians for trial on private patients and attempt to correlate what amounts to a great deal of fragmentary and uncontrolled data. These widely scattered clinical observations leave much to be desired from the standpoint of comparable patients, similar circumstances of use, and uniform interpretation of results. Observations of a few patients by each of a large number of physicians may give a general idea of therapeutic effectiveness and are likely to uncover some, if not all, of the adverse or untoward reactions of new drugs that may be expected to occur when they are released for general distribution. Such data, however, should not be regarded as a substitute for a carefully designed clinical study of institutionalized or clinic patients which can be conducted under controlled conditions and the supervision of an expert investigator.

It has become quite clear from the scientific data made available to the AMA Council on Drugs at the time new drugs are placed on the market, that clinical studies are correspondingly incomplete or inadequate. Part of this deficiency stems from the fact that laboratory and clinical evidence of safety, rather than efficacy, is the primary legal requirement for placing new drugs on the market. Another reason is the time lag involved in the completion and publication of carefully designed studies of therapeutic effectiveness which may have been sponsored by a manufacturer, but which are not available when the drug is released for general distribution. Sometimes more conclusive studies, although completed, are not published for a year or more afterward, because of the backlog of papers which are awaiting publication in medical journals. Occassionally, investigators withhold publication of preliminary observations in order to carry out more definitive studies. Thus, new drugs sometimes appear on the market before reasonably conclusive clinical reports can be found in medical publications. All too often, early clinical studies do not provide observations comparing the effectiveness of a new drug with longer established drugs or other forms of therapy.

It is important to emphasize that the calibre of drug research has advanced greatly during the past decade through the cooperative efforts of industry, the medical profession and their colleagues in the basic sciences. All interested groups also would agree that there is room for further improvement in the manner in which new drugs are studied, especially in the clinic. Perhaps academic institutions and clinics with the best facilities should open their doors a little wider

to the investigation of industry-developed compounds on the basis that negative results are sometimes as constructive as the more exciting prospect of new discoveries.

Multiplicity and Complexity of Drugs

The incentive of our competitive system of free enterprise has stimulated industrial production of new and better drugs to a degree that can be found nowhere else in the world. Indeed, the American market offers an array of drug preparations so vast that no one individual can name or remember more than a small proportion of them. There are dozens of antihistamines for allergy, more than a score of antibiotics for treating infections, and numerous anticholinergic agents for the management of peptic ulcer. Numerosity of compounds can be applied to almost every known class of drugs. While the development of many closely related drugs for the same purpose has created considerable confusion in the choice of drug to be prescribed, it should be emphasized that the production of similar compounds is the logical outgrowth of free competition. Without this, we could not have made the tremendous progress in drug development which has taken place in the United States. Thus, it is well to remember that the formidable number of "me too" compounds which have been made available is a consequence of the same incentive which has made significant improvements in therapeutics. Moreover, it should not be surprising that attempts to improve upon the first new drug of its kind to be developed are likely to fail more often than they are to succeed. Physicians in their understandable zeal to obtain drug preparations for a special purpose or their own convenience, sometimes are responsible for the manufacture of minor modifications of drugs. A casual suggestion to a manufacturer's detail representative that it would be helpful to have another injectable or oral form of a drug, or a particular combination of drugs, is sometimes the starting point for their development. Confidence in a particular manufacturer also may motivate the suggestion that it should develop a drug like one of its competitors. There is occasionally also a reluctance to abandon drugs which have failed to live up to expectations or have been supplanted by better agents.

Manipulation of the chemical structure of new compounds and the correlation of structural characteristics with pharmacologic action has been a most fruitful source of advancing our knowledge of drug actions. Antihistamines used in allergy have shown local anesthetic properties as well as the accidentally observed action against motion sickness. In recent years, many new drugs which exhibit multiple unrelated pharmacologic effects have been developed. The complexity of these actions is even more baffling than the number of new compounds. The physician accustomed to administering drugs having a single or, at most, two parallel actions, has found it difficult to learn the multiphasic pharmocology which is exhibited by some of the newer drugs. Probably the most striking example of this kind is the group of so-called "tranqualizers" which are derived from phenothiazine. Phenothiazine, which originally was used as a veterinary vermifuge too toxic for humans, has been transformed to make chlorpromazine (Thorazine) and a growing number of related derivatives. They exhibit such multiphasic actions as central depression, including antiemesis, together with weak adrenolytic, hypotensive, antispasmodic, hypothermic and antihistaminic effects. Some of these derivatives already have been altered chemically to make them primarily antiemetic. Accordingly, it can be seen that modifications of older compounds open the way for exploring ever changing avenues of research and the development of additional new compounds for clinical use. This continuous flow of new drugs makes it incumbent upon the physician to keep abreast of the expanding knowledge in therapeutics. The challenge can best be met by acquiring completely objective information on each new drug. Successful use of a new drug often hinges upon a thorough understanding of its properties, indications, hazards, administration and dosage.

Summary

Interpretation of reports on new drugs is an important aspect of their evaluation as therapeutic agents. Progress which has been in the methods for their experimental study still leaves much room for improvement, especially in trials on human subjects. The multiplicity and complexity of drugs presents a challenge to the manufacturer, the investigator, the educator and the practicing physician to find more efficient ways for the comparative clinical study and rational application of new compounds. Better methods of clinical study, interpretation and publication of results as a basis for the introduction of new drugs would seem to offer the greatest potential for future progress in therapeutics.

Today's Challenges for the Health Team

Eugene N. Beesley
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THE THEME of this conference, "Tracking Tomorrow's Medicine Today," is a subject which concerns every member of this country's health team and is of particular significance to the pharmaceutical industry, which is constantly striving to discover, produce, and distribute new medicines for the treatment of disease.

As the decade of the 1960's begins, it is worthwhile pausing for a moment to appreciate the fact that American citizens have available to them today scientific medical care of a quality never before obtainable in history. New heights of medical care have been reached; many diseases which were dreaded names at the turn of the century have been conquered or brought under control; the standard of public health has been greatly raised; and man's life span has been considerably lengthened.

It is paradoxical that these successes have been accompanied by widespread criticisms. Most members of the American health-care team have felt the sting of public censure in recent months—physicians, pharmacists, hospitals, and, last but not least, pharmaceutical manufacturers. Let it be said that public scrutiny, in itself, can serve useful purposes in a democratically organized society—and frequently does. But it should also be emphasized that public opinion which is based on misconceptions and misunderstandings can be very damaging—damaging, in fact, to the public's own best interests.

During the recent past, we have had some evidences of this. And I am deeply concerned that a lack of public understanding of the true facts about medicine and medical progress is causing doubt to be cast on the integrity of drug manufacturers, the efficacy of drugs, the ethics of the medical profession, and on the quality of treatment in hospitals.

There is not time in this presentation to discuss all aspects of these matters. However, I should like to review some of the charges which have been leveled at drug manufacturers—and which, directly or indirectly, concern physicians as members of the health-care team.

Both physicians and pharmaceutical manufacturers are well aware that there has been growing public interest in drugs. This is natural, since medicine plays an increasingly vital role in the everyday lives of millions of people. There is, no doubt, a widespread belief that drug prices are "high" or even "too high." But "too high" in relation to what? Are the prices paid by consumers too high in relation to the benefits received? Have drug prices risen out of proportion to other commodity prices? Does the industry's price performance have beneficial or adverse effects on our economy and on medical progress? These are important questions we must seek to answer.

There is certainly no evidence of an inordinate increase in retail drug prices. In fact, according to Dr. Jules Backman, professor of economics at New York University, Americans today would be paying a *billion dollars a year more* for drugs if the price of medicine had gone up only as much as the total cost of living since 1939.

A recent release by the American Medical Association—which quotes as source for this material the U. S. Department of Commerce and the AMA's economic research department—shows that a smaller per cent of the consumer's medical dollar was spent in 1958 for the direct purchase of drugs than was spent twenty years earlier. In 1938, the consumer's direct expenditures for drugs amounted to 22 cents out of the medical dollar; and in 1958, they were 20 cents. The Department of Commerce figures include only *direct* purchases; and so they do understate, to some

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extent, the proportion of the medical dollar which is spent on drugs.

Public misunderstanding regarding today's prices of prescription medicines stems, perhaps, from two measurements of pricing performance which can be misleading—total consumer expenditures for drugs and average prescription prices.

Perhaps the basic cause for concern by the individual consumer is the fact that he is spending more money for drugs than he used to spend. Total direct consumer expenditures for drugs increased from $1,466,000,000 in 1948 to $3,261,000,000 in 1958. Annual expenditures per capita increased from about $10 to about $19. Increased total expenditures for medicine do not, however, necessarily reflect increased prices. They can and do reflect increased consumption. Actually, the principal reason for higher consumer expenditures for medicines is simply that many more beneficial medicines are now available to the consumer than ever before in history.

In prior years, people afflicted with pneumonia, tuberculosis, mental illness, heart or circulatory diseases, and many other killers and cripplers spent relatively little money for drugs because no effective remedies could be purchased. They often incurred relatively heavy expenditures for hospital bills, physicians' services, and other costs of illness and disability—and, of course, loss of income. Today, a host of new drugs prevents, cures, or relieves these diseases. Increased expenditures for these medicines reflect the *availability* of medicines which could not be bought before at any price.

So increased consumer expenditures, in themselves, prove little or nothing about drug prices.

A second point of misunderstanding, perhaps, centers around another statistic—*average prescription price*. This figure is reported by a number of trade sources and is derived simply by dividing the total dollars spent for prescriptions in a given year by the total number of prescriptions. On this basis, the average prescription price doubled between 1948 and 1958. The consumer who paid $1.51 for the "average" prescription ten years ago will pay approximately $3.00 for the "average" prescription today. When compared in terms of a constant dollar, the increase is from $1.51 ten years ago to about $2.50 today.

But this yardstick is also virtually useless as a sound measurement of drug pricing performance, for it compares almost totally different things. The "average" prescription today involves products, processes, and benefits which did not exist in 1948. The most important change in prescriptions since 1948, as you well know, has been the change in the medicines prescribed.

Such complex products as broad-spectrum antibiotics, hormones, corticosteroids, and tranquilizers are very much a factor in "average prescription price" today, while they were nonexistent or quite different in 1948. Comparing "average" prescription prices over a period of years is like comparing prices of a one-engine airplane of thirty years ago with a Boeing 707 jet transport. You would hardly conclude that the price of a 707 jet is too high, *per se*, because it costs more than Lindbergh's *Spirit of St. Louis*.

The growth and accomplishments of the pharmaceutical industry's research and development programs during the last decade have been a noteworthy phenomenon even in an age of general scientific and technological revolution. Last year, the industry spent about $200,000,000 in the search for new medicinal agents.

In the last decade, the ethical pharmaceutical industry introduced 392 previously unknown medicinal chemicals—the products of research. Fully 70 per cent of the prescriptions written today could not have been filled twenty-five years ago. Almost 45 per cent could not have been filled even five years ago.

And yet, a small number of highly vocal critics have implied recently that the industry's research and development efforts have been overrated, that they have produced few scientific discoveries of real consequence, and that they have flooded the market with products of little significance. What are the facts?

Of course, pharmaceutical industry scientists do not make *all* the original discoveries that lead to new medicines (although they have made a fair share of them). But the basic research breakthrough is almost always only the start of the scientific struggle to develop a safe, effective, stable product that can be manufactured in quantity, and this is where the industry has scored some of its most notable achievements. Unless there is success in the industrial development laboratory, the most brilliant research discovery remains little more than a scientific curiosity.

The fact that the pharmaceutical industry *does* produce a significant number of original discoveries is recognized in a report issued to the British Ministry of Health in 1959 by a committee under the chairmanship of Sir Henry Hinchliffe. The report draws attention to the discovery of penicillin by Sir Alexander Fleming and that of streptomycin by Dr. Selman Waksman and his associates at Rutgers University, and then states that *"all of the subsequent antibiotics were discovered by scientists working in the labora-*

tories of pharmaceutical firms, almost all in the U. S. A." The report also pays tribute to the industry in the development of the sulfonamides, penicillin, and the corticosteroids.

These accomplishments speak well for the American drug industry's willingness to take risks, its financial structure, and the capabilities of its scientists and medical researchers.

A new drug discovered tomorrow is too late to save a life lost today. This might well describe the philosophy behind pharmaceutical industry research.

One of the criticisms leveled at drug manufacturers recently has been that too much money is spent in the promotion and advertising of products, and I should like to discuss this charge with you.

The most costly drug in the world is the one not available when and where it is desperately needed. I am sure you will agree that rapid distribution of new medicinals, along with information about their proper use, is often a matter of life or death.

American pharmaceutical manufacturers have the reputation of getting new products and information to physicians faster than the drug manufacturers of any other country in the world. To do this, the companies use the highly competitive tools of salesmen, professional journal advertising, and direct mail—tools used by most American industries. For this, the drug industry has been criticized and has been charged with spending too much money on these activities.

In my opinion, the most important factor in a program of product information and promotion is the salesman, or detail man, as he is frequently called. He acts as the "transmission belt," relaying information from research physicians and independent clinicians to their colleagues who are in active practice. This professional service reduces the "time lag" between scientific discovery and its application. The salesman's service to the medical profession is difficult, highly complex, and technical. Also, he keeps pharmacists informed about research findings.

The importance of the pharmaceutical salesman is indicated in a survey sponsored by the American Medical Association in 1958. It was entitled, "Attitudes of U. S. Physicians Toward the American Pharmaceutical Industry," and it showed that 68 per cent of the more than 1,000 physicians interviewed stated that detail men are among the two or three most important sources of their new product information.

In order that you may be able to appraise the charge of excessive spending in sales promotion, I want to reveal to you the cost of Eli Lilly and Company's activities in these fields. If we had no salesmen and if we did no advertising of any kind, approximately 6 cents would be eliminated from the company's share of each dollar that the consumer spends for a Lilly product. Of that 6 cents, about 4 cents is required to pay for the service that is rendered by our salesmen. This covers their compensation and expenses. Approximately 2 cents goes for professional journal advertising, direct mail promotion, and product samples.

I submit to you that 6 cents of the consumer's pharmaceutical dollar is not an exorbitant price to pay for a professional communications program of such importance.

With some exceptions, I think the ethical pharmaceutical manufacturers have done a good job of providing information to the medical profession. Occasionally, overenthusiasm may have adversely influenced the accuracy of a new drug presentation, but no reputable drug manufacturer would attempt to defend such a situation. More and more safeguards are being adopted by the industry to protect against such inaccuracies, not the least of which are the competent medical staffs of the responsible producers who have the final word for the company on what can and what cannot be said about a new drug.

Another area relating to the marketing of pharmaceutical products which is little understood by the general public is the controversy over generic name versus trademark labeling of products.

As in any manufacturing industry, pharmaceutical manufacturers could not hope to meet competition and maintain the sales of any product which does not have a name. It is difficult to imagine the Ford Motor Company urging the public to buy an "automobile" instead of a Ford automobile, or RCA asking the public to buy a "TV set" instead of an RCA set.

Behind trade names of products lie the reputation, skill, and integrity of the manufacturers. Each member company of the ethical drug industry strives to excel in its products and to make them known through professional channels so that they will be used and large-scale production can be maintained.

Brand name identification is particularly vital for the innovating companies, which account for the majority of new drug advances. These innovating companies take the initial risk of enormous research and marketing investments to make their new drugs available on the shelves of the nation's drug stores, and always with the possibility that the new product may quickly become obsolete.

Frequently, the innovating firm's only protection in maintaining the market it has developed and its only basis for anticipating sufficient sales to cover the costs that made the drug available in the first place are the confidence and trust physicians associate with the company's brand name.

By brand name prescription, too, you as a physician order for your patient a specific product about which you have knowledge as to quality, purity, and any side effects that might have importance for a particular patient. Brand names stand not only for the active ingredient or ingredients but also for special excipients, vehicles, and bases, frequently developed by costly research to be nonallergenic, specially buffered to promote tolerance, sugar-free for the obese and diabetic, and for many other important variations for individual patient needs. With these differences existing, it is doubtful that you would want your patients to take "pot luck" with a generic equivalent.

As a pharmaceutical manufacturer, I share, along with you and other thinking people, concern over the increasing costs of medical care and many other essential goods and services. I, too, am attentive to the criticisms and suggestions for changes in our system of medical care which one hears these days.

We face two big responsibilities. First, to the extent that complaints and criticisms are justified, we must strive to make improvements. There are many heartening evidences that this work has been going forward on many fronts—and it must continue.

Our second responsibility must not be overlooked. As a result of the experiences which I have had in recent months, I have come to the conclusion that the health-care team has done a much better job of providing for the care of the sick than it has done in telling its story to the public. In other words, we must all do a better job of public relations.

In areas in which the public is poorly informed or misinformed, all members of the health team have an obligation to establish better communications on the local, state, and national levels. We must find out exactly where misunderstandings lie. In our daily contacts with people, all of us frequently have an opportunity to uncover causes of misunderstanding and dissatisfaction. And we should never underestimate the potential of person-to-person discussions to improve the situation.

There is much that members of the health-care team can do on a group basis to improve their relations with the public. Community attitude surveys, for example, have been used by local medical societies and other organizations to reveal dissatisfactions and misunderstandings and then to undertake constructive programs to improve conditions. Public relations action at state and national levels is sometimes more spectacular, but I am confident that grass roots efforts can do a better job of pinpointing problem areas and, possibly, contribute to more lasting improvement in relationships with the public.

The truth of the matter is, the need for better communications by the health-care team is so great that responsibility must be accepted by *individuals*, by *local* and *county* organizations, by *state* and *national* groups. In addition, liaison between the various components of the medical service field must be further strengthened.

As a member of the pharmaceutical industry, which is very much interested in strengthening this liaison, I am particularly pleased to have been invited to participate in this Clinical Institute.

Cancer Incidence in Urban and Rural Areas of New York State

The New York State age-adjusted incidence rates for several cancer sites are compared with rates reported from Connecticut and Iowa. Despite some differences, there is substantial agreement among the three sources on the approximate magnitude of the incidence rates, for several sites, in the urban and rural areas and in the urban-rural ratios of rates. Some of the larger urban-rural ratios were noted for the respiratory system, esophagus (males), and intestine and rectum (males). Within New York State, the urban-rural differences in incidence for specific sites persisted when data for metropolitan and nonmetropolitan counties were examined separately.—Morton L. Levin, William Haenszel, Benjamin E. Carroll, Paul R. Gerhardt, Vincent H. Handy, and Samuel C. Ingraham II, New York State Department of Health, Albany, New York, and National Cancer Institute, Bethesda, Maryland. *J. Nat. Cancer Inst.*, 24:1243-1257, 1960.

Physical Diagnosis Course Available On Sound Color Film

Frederick J. Margolis, M.D.
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FOR the last three years, Wayne State University College of Medicine, Department of Medicine, has been producing a series of sound-color motion pictures on Physical Diagnosis. This project is designed to utilize the talents of many outstanding teachers from different medical schools across the country. An authoritative and talented teacher in each field has been asked to narrate each reel, demonstrate the diagnostic signs, and relate the significance of the signs. It is hoped that the quality of the teaching experience will be enhanced when the personality of a good teacher is combined with a fairly complete bank of cases. It is also expected that much can be gained in watching the style of clinicians from different parts of the country as they actually work with patients. This could be especially valuable for those who have had all their training in one institution. Not more than one reel has been produced at any one medical school. Most of the narrators have written textbooks in their special fields, which will be of interest to the viewer if he is familiar with written work of the teacher.

Through the use of film, it is possible to bring a semi-live clinic of a large group of selected cases to the practicing physician in his own hospital or county medical society meeting. The use of film also makes it possible to bring a large selection of cases together that would not even be possible in a large medical center without spending many weeks waiting for the patients to appear. The first six reels presently available are:

1. *The Ear and Hearing*, with Dr. George Shambaugh, Jr., Northwestern University.
2. *Communicable Diseases*, with Dr. Lewis Weinstein of Tufts Medical School.
3. *Gait and Musculoskeletal Disease*, with Dr. William T. Green of Harvard.
4. *The Larynx*, with Dr. Paul Holinger, University of Illinois.
5. *Disorders of Motility*, with Dr. A. M. Ornsteen, University of Pennsylvania.
6. *Disorders of Speech*, with Dr. Charles Van Riper, Western Michigan University and Dr. Frederic L. Darley, State University of Iowa.

The reels on *The Face*, with Dr. Muir Clapper, Wayne State University College of Medicine, will be available in March.

The object of this project is to bring refresher material in diagnosis to the practicing physician. The project will also make cases available for the medical student and the nurse when they are needed for their teaching program. Patients with communicable diseases are infrequently available for teaching purposes because they are usually not hospitalized. These cases can be collected and presented in a film such as this. Certain diagnostic signs are especially well taught on film, for example, ear drum pathology, laryngeal tumors, neurological signs, and communicable diseases, to mention only a few.

The long-term plan is to make a reasonably complete series of films on physical diagnostic signs for medical students, physicians and nurses. We hope to document the talent of leading teachers in many medical schools about the country. Following is a brief outline of the available reels.

Physical Diagnosis—*The Ear and Hearing*, with George E. Shambaugh, Jr., M.D., Northwestern University—22 Min. sound-color

A brief review of the anatomy of the ear and hearing mechanism is presented. A few cases with disorders of the external ear follow. The method and necessity of cleaning the external auditory canal precedes the presentation of a series of typical tympanic membrane disorders. The method of testing for patency of the eustachian tube; tests for determining an active or inactive labyrinth; and the hearing tests—as well as the differentiation of nerve from conductive deafness follow. Three types of facial nerve paralysis are presented. The reel concludes with a demonstration of the effect of deafness on speech. Three patients with varying degrees of deafness speak with their characteristic voice changes.

Physical Diagnosis—*Communicable Diseases*, with Louis Weinstein, M.D., Tufts Medical School—30 Min. sound-color

In a brief prologue Dr. Weinstein points out the need for teaching material in this area—that many students do not see

many of the communicable diseases in their training period. The following cases appear and are described: Roseola infantum; two patients with German measles; two patients with chickenpox; four patients with all stages of measles; two patients to show the differentiation of mumps from cervical adenitis; four patients with all stages of scarlet fever; typical staphylococcal lesions; mouth lesions of herpes simplex, acute herpetic stomatitis, and fungus infection; three children with whooping cough including the sound of the paroxysm; encephalitis with the sound of the typical shriek; three patients with different kinds of meningitis including the rash of meningococcemia; a patient with the diagnostic signs of acute poliomyelitis; a patient with disseminated tuberculosis; and finally a patient with blastomycotic lesions of the skin.

Physical Diagnosis—*Gait and Muscoloskeletal Disorders*, with Wm. T. Green, M.D., Harvard Medical School—30 Min. sound-color

The mechanism of normal gait at normal and slow motion is presented and described by Dr. Green. Several patients are presented who show characteristic gait changes that result from certain muscle weaknesses and paralysis. Three and four point gaits are analyzed. Gluteal weaknesses, quadriceps and peroneal weaknesses are demonstrated. The findings in muscular dystrophy are presented followed by a patient with musculorum deformans. Six diagnostic signs of congenital hip disease including the x-ray findings are described. The same type of presentation is made with a patient having a slipped femoral epiphysis. Spastic gait is presented and finally the antalgic gait and its causes are described.

Physical Diagnosis—*The Larynx*, with Paul H. Holinger, M.D., University of Illinois—16 Min. sound-color

Dr. Holinger describes how normal voice is produced. Animation is used to show air flow through the upper respiratory tract. The causes of hoarseness are discussed and a demonstration of the examination of the larynx with the laryngeal mirror is presented. A series of patients with voice changes from different etiologies are allowed to talk. Dr. Holinger describes the type of hoarseness in each case and demonstrates the changes in the larynx by direct examination, with motion photographs made with his special endoscopic camera that gives an unusually clear view of the lesions themselves. He also gives the differential possibilities as he does the physical examination of the neck. A clear definition of the importance of hoarseness is made, the causes enumerated, and the proper physical examination presented.

Physical Diagnosis—*Introduction to Speech Problems*, with Charles Van Riper, Ph.D., Western Mich. University, and Frederic L. Darley, Ph.D., State University of Iowa—30 Min. sound-color

This film presents a brief review of the incidence, etiology, and nature of the various speech difficulties. A breakdown of the various kinds of speech disorders is made and examples of these types are presented. There are patients with articulation problems; different degrees of stuttering; delayed speech; dysarthria related to cerebral palsy; speech problems related to defects in the oral structure; and those with abnormal voice quality. Drs. Darley and Van Riper make a definition at what age apparent abnormalities in speech require treatment and when delayed speech is significant. This reel is designed to show the wide variation in causes of abnormal speech—both organic and functional—and how they relate to the growth and development of speech. It gives the physician an opportunity to understand how he may be able to prevent a possible permanent speech disorder of the functional type, as well as to broaden his concept of many organic diseases where speech defects play a role.

Physical Diagnosis—*Disorders of Motility*, with A. M. Ornsteen, M.D., University of Pennsylvania—35 Min. sound-color

This film gives a fairly complete coverage of neurological conditions as they relate to changes in motility. In Friedreich's Ataxia the waddle, typical foot deformity, reflex changes, and speech defect are presented. Two patients with dystonia musculorum deformans follow. Four patients with variants of cerebro-spastic paralysis are seen—quadriplegia, hemiplegia, gait, speech, facial changes, tongue motion defect, and emotional change. Huntington's degenerative chorea of adults is presented. The two types of muscular dystrophy seen are the pseudo-hypertrophic type and facial-scapulo-humeral variety. Several cases are presented that show changes related to the cardiovascular system; the small step gait (stuttering steps) due to both arteriosclerosis and carbon monoxide poisoning; hemiplegia with clonus of wrist and ankle, face and tongue deviation, and Hoffman reflex; monoplegia involving the left leg. Both types of paralysis agitans are presented with the following signs discussed: the fixed posture with unswinging hands, cog-wheel rigidity, propulsion and retropulsion, the typical tremor, the typical hand positioning, and the test for rapid muscle fatigue. Patients with the cord lesions of poliomyelitis, neuritis and tabes dorsalis are seen. Five cases of multiple sclerosis demonstrate the wide variety of signs and emotional display. Two patients with ataxia conclude the reel: one due to brain tumor involving the pyramidal tract and one post-encephalitic in origin.

These films are available for use by any county medical society, medical school, hospital staff or nursing institution. They may be requested from the Audiovisual Utilization Center of Wayne State University, Cass Avenue, Detroit, Michigan. They may be used on a service charge basis of $5.00, or prints may be purchased at cost.

"We must all be born again atom by atom from hour to hour, or perish all at once beyond repair."—CHIEF JUSTICE HOLMES

Lipoma of the Heart

A Review of the Literature

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A GIVEN INDIVIDUAL concerned with a particular field of endeavor, the owner of a real or fancied insight into human nature, may find interest in the contemplation of probable thought and emotional patterns of previous generations as they considered the future from their own "modern" outlook. In the medical field, for instance, one might be able to note the person who thought that contemporary attitudes and techniques were the ultimate of refinement. On the other hand, there must have been an equal or greater number of people who felt, as did the founders of our Constitution, that the passage of time with improvements in techniques and changes in concepts, might afford a sort of Elastic Clause type of future for their profession. Time has shown that the latter group of persons were on the right track, as evidenced by the progress and changes of the organized profession.

Developments in surgery and its subspecialties, utilization of new diagnostic procedures, and the use of recently-discovered drugs are factors that are tending to change the outlook on many disease entities from that of a passive role of observation to an active one of treatment. Syndromes, anatomic oddities, and physiologic aberrations, once classified under the heading of "interesting case reports," are now being viewed with the idea of cure and are therefore seen more in the literature than formerly; more precise descriptions and studies dealing with them are becoming commonplace.

The general subject of cardiac tumors, well described for some decades in the European and American literature, is one of the many facets of recent study secondary to the above concept and subject to newer investigative and therapeutic tools. German workers[8,19,20] of some decades past concerned themselves primarily with metastatic lesions to the heart, although primary tumors were often mentioned.[6] Bradley and Maxwell[1] in their 1928 study based upon such articles and upon their own observations, concluded that fibromas, rhabdomyomas, and myxomas were the most commonly seen forms; secondary tumors were usually due to direct extension from contiguous structures. Metastatic tumors are touched upon frequently in the reviews of recent years. Lisa, Hirschhorn, and Hart[11] summarized some of this work and added their own cases; Prichard's article in 1951[16] dealt mainly with metastatic growths. He considered them twenty to forty times as common as primary lesions. Field, Donovan, and Simon[4] reported an incidence of primaries as 0.03 per cent among routine postmortem examinations. Likoff, Geckler, and Gregory[10] collected 348 cases of primary tumors; benign lesions were considered of mesoblastic origin, with myxoma, rhabdomyoma, and fibroma as the predominant histologic types. Lipoma, angioma, leiomyoma, teratoma, and xanthoma were noted, but were considered rare.

The relative rarity of cardiac lipomas must then, as it has in the past, serve as an excuse for this review of the literature; the histologic picture of a benign disease also serves to place these growths in a position of possible cure by surgery if they can be diagnosed. Accordingly, an attempt has been made to compile a summary of the previous reports concerning this tumor, as well as certain data regarding clinical and histologic features as well as are known. To accomplish this, the three previous summary articles[12,13,21] to which most later writers refer were reviewed. (Many of the excellent studies in the German writings of the past six decades dealt with the subject of cardiac tumors in general, either in a handbook or textbook form, or in the presentation of individual reports or groups of cases. As a rule, these sources, together with separate instances from the French and Italian archives, served as basic ref-

The Author

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TABLE I. COMPILED FROM VERLIAC, MOREL, AND MARTIN
Translation and Summary

Author	Lesion (Gross)	Lesion (Microscopic)	Location of Lesion	Clinical Signs, Age, and Sex	Size	References
1. Albers	Lipoma. No capsule, but limited from muscle	Fibro-lipoma	Apex of left ventricle invading the myocardium	No signs. 77-yr.-old man	"Hen's egg"	Virchow's Archives, Bd. X, p. 215, 1856
2. G. Banti	Sessile lipoma; no distinct capsule	Pure lipoma	Between inferior vena cava and tricuspid valve	None. 52-yr.-old woman	Cherry size: 2-cm. diameter	Lo Sperimentale, fasc. 9, 1886
3. Handford	Unencapsulated lipoma	Lipoma: ?fatty degeneration of adjacent myocardium	Interauricular septum	None. 76-yr.-old woman	Pigeon's egg	Brit. M. J., p. 56, 22 Jan., 1887
4. Caryophyllis	Pedunculated; 1-cm. pedicle. Dog's ear in appearance	Fibro-lipoma	Origin in right auricle, between superior and inferior vena cavae; covered the right side of the I.V. septum and involved both the right auricle and ventricle	None	8 to 9 cm. long. Free portion 6x3 cm.	Bull. de la Soc. Anat. de Paris, p. 202, Mar., 1889
5. Tedeschi	Sessile lipoma	Myolipoma. Covered with endocardium. Fibromuscular septae extended into tumor	Confined to the apex of the right ventricle	None	2.6x2.1 cm.	Prag. Med. Wocheuchr., nos. 11, 12, 1893
6. Petrocchi	Ovoid, sessile, tricocular, lipoma	Covered by endocardium. No zone of transition between tumor and myocardium	Right atrium, between the two caval orifices	None. 77-yr.-old man	"Pigeon's egg." 5.5x8.5 cm.	Lo Sperimentale, p. 80., 1897
7. H. Spalty	Pedunculated lipoma. Projected into lumen	Myolipoma. In muscle, covered by endothelium except at the level of the pedicle	Right auricle, between the pectinate muscles	None. 40-yr.-old woman	Lemon seed size. 1.2x0.7 cm.	Inaugural Dissertation, Zurich, 1901
8. Ribbert	Lobulated lipoma	Pure lipoma which infiltrated musculature	Anterior musculature of the left ventricle and I.V. septum	None	4x2 cm.	Geschwulstlehre, Bonn, 1905
9. Brewis	Pedunculated lipoma; obstructed tricuspid valve	No microscopic description available	I.V. septum at midpoint; directed up and back; valve occluded	Sudden death. 7-month child (female)	5 cm. diameter. Weight 9.5 grains	Lancet, p. 829., 16 Sept., 1905
10. Vaughn, McKeehnie	Pedunculated subpericardial lipoma	No microscopic description is available	At transverse sinus of pericardium under left branch of pulmonary artery and ending on left auricle	None. 56-yr.-old man	7x4 cm. 19 ounces in weight	Brit. M. J. p. 76, 14 July, 1905
11. Struppler	Two ovoid lipomas	No description	Transverse sinus of pericardium; covered anterior surface of ventricles	None	Not given	Munchen med. Wchnschr. 5 Mar., 1907
*12. Struppler	Lipoma	No description	Subendocardial in the left ventricle	None	Almond size	Lehrbuch der Spez. Path. Anat. de Orth, 1887
*13. Struppler	Lipoma	No description	Septum of left ventricle	None. Patient had a lipoma of the thigh as well	Bean size	Same as No. 12
14. Verliae, Morel	Sessile lipoma. Right auricle hypertrophied; mural thrombus, right auricle	Pure lipoma	Left half of tricuspid valve orifice. ? possible obstruction	Postoperative death (appendectomy). Mitral vegitations; ? active rheumatic carditis. 16-yr.-old girl	5x1 cm.	Etude sur le Lipome du Coeur. Arch. des Maladies du Coeur., 1909

*Data recorded on these two lesions are taken from the original report by Johannes Orth in his handbook of pathology.

The following cases, originally reported by their authors as lipomas of the heart, were subject to correction in later years. Several had been listed on the charts of Verliac and Morel for the sake of completeness. One case, reported by Geipel as a lipoma, was later diagnosed as a sarcoma (original report in Munchen. med. Wchnschr., p. 2207, 1904) and the three below were discussed at some length by Handford, as he presented his review to the London Pathological Society.

a. St. Bartholomew's Hospital Museum Specimen: Several small masses of yellowish, firm substance were found along the middle posterior wall of the left ventricle. The largest mass was seen to project externally, and to possess a fibro-cellular capsule. The pericardium was adherent to this mass and to the adjacent heart wall. There was no sign of a clinical heart disease, although the patient complained of pain in the anterior chest prior to death. The diagnosis was "tumor of the heart, of uncertain origin." There was no report of a microscopic diagnosis.

b. Queen's College Specimen: Professor B. Windle studied this material, and felt that the fatty growth present should be labeled as fatty deposition and probably fatty infiltration of an extensive kind rather than lipoma.

c. The College of Surgeons of England Museum: Sheep's heart which showed a burrowing of fat into the muscular substance with projections into the cavities of the organ.

Bundschuh felt that these cases represented instances of lipomatosis cordis.

TABLE II. FROM MAHAIM
Translation and Summary of Additional Cases

Author	Lesion (Gross, Microscopic)	Location of Lesion	Clinical Signs	Size	References
1. *Gernet	Multiple small lesions in heart. There is no gross or microscopic description given. The patient had multiple fatty lesions on thighs and psoas muscles. Read microscopically as probable liposarcoma	About "ten" lesions in the heart; one on face of right ventricular wall, one in aorta, and one in right auricle	None. Tumor of leg weighed one kg.	Small	Fall von Infectiosem Lipoma (Lipoma medullare) Virchow's Arch., 41: 534, 1867
2. Kirch-Hertel	Several scattered small lipoma in subendocardial and subepicardial areas of heart. Same patient also had a fibroma of the stomach, a lipoma of the peritoneum, tumor of a kidney vessel, and degenerative vascular disease	Not described, other than in general locations	None	?	Zentrbl. f. Path. (Sond-Abdr. Festschrift Schmidt) 33: 65, 1923 "Tuberoser Hirnsklerose mit verschiedenartigen missbildungen und Geschwulste"
3. Roulet	Lipomas	10 small tumors; one localized at wall of left ventricle—also involved: superior part of I.V. septum	None	?	Virchow's Arch., 15, p. 277, 1930. "Das Primare Retothelsarkom der Lymphknoten"
4. Neugebauer	? Lipo-fibro-angioma	Anterior wall of left ventrical	None		Zentrbl. f. Path., 2: 70, 1938. "Hammartom des Herzens,"

*Gernet's case, because of its place in time and interpretation, may not be a true lipoma. Factual data on the remainder of these cases are sparse.

erences to the summary articles of Verliac and Morel, Martin, and Mahaim. As their three bibliographies were studied, a repetitive trend in the use of source material was noted; often the same original workers antedating the time of a given article were quoted with their choice of cases. This procedure may have led to the omission of certain articles in the summaries: Orth's[14] two cases, cited under Strüppler's name by Verliac and Morel, and the works of Pasini[15] and Cellina,[3] referred to by Mahaim. The lesions reported by Klob,[9] Dittrich, and Bundschuh[2] were found as individual items following a study of other dissertations and their reference material. Cellina's work provided the fourth case recorded under Strüppler's name; this is reported as a "personal observation." There are also two instances of cardiac lipomas reported by Kaufman in Cellina's work. It is reasonable to suspect that still other stories may have been overlooked in the annals of various nationalities and that more than the apparent number of cases collected here actually exist in the literature).

Perusal of the foreign literature, grim as it may sound, was not unrewarding from a literary as well as a factual standpoint. One is moved to recommend the study of Verliac and Morel for its expression of Gallic temperament in their reflection of how far medical thought had progressed up to that modern era (1909) in regard to cardiac tumors. The story of their case was interesting in itself from the standpoint of differential diagnosis; as well as pointing up the almost casual way that cardiac tumors are found at necropsy examination (a fact as true today as it was then), it illustrated a possible instance of clinical significance regarding partial valve blockage. This, with Brevis' case, represented the only two known occurrences of this nature. Suspected valvular or large vessel embarrassment may be inferred from the items cited by Cellina, Pasini, and Kaufman. A study of the history of Medicine and Pathology in general during the period 1875-1925 suggested that the French and Italian workers were somewhat displaced by the ponderous and detailed efforts of their Teutonic contemporaries. This latter group of workers seemed to offer the greatest number of individuals who tried to form conclusions from the sparse data available to them concerning cardiac lipomas. Much of this material was reported as second-hand observations, or in a very limited manner regarding details of histology and anatomy. Photographs and sketches were rare. In the presentation of the previous charts of workers on the following pages of this review, additional data have been added as facts became

TABLE III. MISCELLANEOUS CASES FROM INDIVIDUAL AUTHORS
Translations and Summaries Where Applicable

Author	Lesion (Gross)	Lesion (Microscopic)	Location of Lesion	Clinical Signs, Age, Sex	Size	References
1. Klob	Lipomatous tumor	None given	Below endocardium of left ventricle, near lower part of membraneous septum	No clinical signs, "Emaciated old lady"	Pea size	Klob, J.: Zur Pathologie der Geschwulste. Cantatts Jahre-Bericht, 4: 313, 1860
2. Pasini	Sissile lipoma	Lipoma. Connective tissue webs passed into the myocardium from the base of the tumor	Posterior wall of the left ventricle, at the base of the bicuspid valve, which was slightly retracted. Projected into cavity of the ventricle	No clinical signs during life. Patient died of gastric carcinoma with hepatic metastases. 64-year-old man	Walnut size. 14 mm diameter, 5 mm base	Pasini, A.: Contributo Allo Studio Dei Tumori Del Cudre. Clin. Med. Italiana, 40: 548, 1901
3. Bundschuh	Whitish, scattered, lipoma-like lesions	Rhabdomyo-lipoma. Difficult to discern lipomatous from myomatous elements	Anterior wall, left ventricle, near apex and septum. (Other scattered subepicardial and subendocardial rhabdomyomas described)	No clinical cardiac signs during life. Noted in a two-year-old girl with "tuberous sclerosis" of dura mater, kidneys, and heart	Pea-sized nodules	Bundschuh, E.: Ein Weiterer Fall von Tuberoser Sklerose des Gehirns mit Tumoren Der Dura Mater des Herzens, und der Nieren. Beit. Path. Anat., 54, 1912
4. Dittrich	Multiple lipoma-like formations	Not available	Intramurally situated in both halves of the heart	No recorded clinical signs. 26-week-old fetus	Not recorded	a. Bundschuh, E.: Beitrage Patho. Anat., 54, 1912 b. Henke, F., and Lubarsch, O.: Handbuch der Speziellen Path. Anat. und Histologie. Berlin, p. 489, 1904
5. Cellina	Large, pedunculated, globular, yellowish tumor	Lipoma	Originated from pulmonary artery trunk and from left branch. Spread over left atrium, almost to division of trachea. Pericardial tumor	Basedow's disease with terminal heart failure in 41-year-old female.?Obstruction of left branch of pulmonary artery by tumor	96 mm x 55 mm x 57 mm	Cellina, M.: Gior. clin. med. 12: 1324, 1931
6. Kaufman	Filiform lipoma. Shiny, white tendinous pedicle	Not recorded	Epicardium	Not recorded	Bean size	Cellina's reference
7. Kautman	Lipoma	Not recorded	Epicardium. Posterior aspect, left ventricle. Apparently penetrated myocardium to correspond with base of posterior part of mitral valve	Not recorded	Chestnut size	Cellina's reference
8. Struppler	Two large, yellow tumors similar to auricles. Cuneiform in shape, with apices down	Adipose tissue. Heart muscle "infiltrated with fat"	Inside pericardium. Seemed to originate on fat pad of the atrioventricular sulcus. Covered by aorta and pulmonary arteries	Death due to miliary tuberculosis in a 62-year-old male. ? of cardiac enlargement to right side of sternum by percussion. ? physical signs due to tumor per se	Right side: Hen's egg size. Left side: "a little smaller"	Cellina's reference. "Personal observation by Struppler," 1907
9. Martin	Lipoma	Pure lipoma, covered with endothelium	5 mm from posterior border of fossa ovalis	No signs. Male, age 47	2.7x2.6x1.8 cm	Martin, E.: Ann. D'Anat. Path., 6,159, 1929
10. Shea and Muehsam	Sessile lipoma	Lipoma. Attached to the underlying atreal myocardium by loose connective tissue which formed a capsule	Anterior wall of the right atrium, 1.5 cm above tricuspid valve	None	4x3x3 cm	Shea, J. P. Muehsam, G. E.: Am. J. Clin. Path., 22: 1081, 1952
11. Gould	Lipoma	Lipoma. No evidence of capsule. Infiltration of adjacent myocardium with fat.	Right antrum. Bulged into cavity	None	3 centimeters in diameter	Gould, S. E.: Path. of the Heart. p. 879. Springfield, Thomas: 1953
12. Brock, D., Finger, J.	Yellow, globular, lipomatous	Polypoid, mature, fatty cells. Projecting surface was covered with endocardium. The adipose tissue was not demonstrated to be associated with the epicardium	Left ventricle, medial papillary muscle	64-year-old female operated for right cerebellar portions angle tumor. No clinical signs or symptoms of heart disease	2.5x1x0.6 centimeters	Brock, D. and Finger, J Am. Heart J., 59: 591, 1960

available from study of original sources cited by these men.

Martin's article in 1929[13] included the earlier observations of Verliac and Morel (Table I), as well as a rather cosmopolitan bibliography. This compilation yielded several additional cases besides his own (which is presented in Table III); Mahaim's 1945 study added a few more (Table II). The several latest offerings on the subject, along with others from older literature not previously summarized, are also included in Table III. Wherever possible, the original articles have been inserted as references in the earlier collections.

This series is small, and exact gross and microscopic observations are lacking in many instances; various suggestions have been offered through the years regarding the nature of these tumors. As stated above, the probable actual incidence of this lesion, recorded or otherwise, is, no doubt, a good deal greater than one might suspect; it tends to be an incidental finding at necropsy, and as a rule is asymptomatic. Martin[13] was of the opinion that as many as a fifth of benign cardiac tumors were lipomas. If they become pedunculated, they may be apparent clinically because of periodic or steady enroachment upon valves or chambers. There appears to be no discriminating factor regarding age, sex, race, physical habits, past or present disease status, or even species. Ages range from a six-month-old fetus to a seventy-seven-year-old man; other factors seem equally well distributed, and numerous reports in veterinary literature are found to indicate a lack of species specificity. Histologically, there have been (in addition to the primary adipose-cell type) combinations of myxomatous, myomatous, and fibrous elements; with the exception of a liposarcoma, they have been benign lesions. Location varied from anywhere in the myocardium to the pericardial sac. Usually they were noted subepicardially in an area of the heart normally devoid of fatty tissue. About a third have been subpericardial, big, and invasive; about half have been subendocardial—again in areas usually lacking in fat.[13] These were usually small and sessile, and were noted in the right ventricle, interventricular septum, and occasionally in the left ventricle.

Multiple theories as to the etiology of these tumors were postulated. Petrucchi suggested degeneration and myocardial infiltration of fat. Thorel[20,22] felt that they arose from foci or fatty metamorphosis in the subendocardium. Foci were found to occur in emaciated persons who failed to show evidence of fat deposits elsewhere.[9] In his work on endocardial tumors, Stahr[19] supposed that endocardial ruptures predisposed to thrombus organization and upon this groundwork, superimposed tumefaction may have developed. However, he did not extend this hypothesis to encompass tumors other than myxomas and angiomas. Bundschuh[2] thought lipomas arose from endocardial or epicardial fatty tissue or from intermuscular connective tissue. Henke and Lubarsch[7] opined that the structure of the heart muscle fibers themselves were a clue to origin; they noted that predilectional places were to be seen at subendocardial or subepicardial areas where specific heart muscles divide. Gould[5] thought that the same changes noted by Saphir and Corrigan[17] actually represented a sort of malignant tumor with respect to invasion into, and alteration of, myocardium; these latter two investigators suggested that the tumors represented circumscribed areas of fatty infiltration or were true benign tumors which are unencapsulated and grow by expansion.

Cellina[3] reviewed the cases of Vaughn and McKechnie and Strüppler; finding their cases similar to his own regarding size and location, he allowed that the weight of the tumor tissue might cause pedunculation and that anatomic position would limit forms and sizes of the tumor, depending upon encroachment upon adjacent structures. Pasini[15] deemed that abnormal development of embryonal mesoderm was the origin of lipomas. However, he cited that Virchow thought an affinity existed between lipomatous and mucous tissues, and mentioned further that Cornil and Ranvier were in agreement with this. According to Buchard (Pasini's reference) the lipomas developed in performed adipose tissue, and some arose from connective tissue without adipose elements. Foerster (Pasini's reference) was of the opinion that embryonic tissue elements were infiltrated by adipose elements; he considered that centers of lipomas in general sometimes disclosed these islands of embryonic tissue.

Summary

A review of the literature dealing with lipomatous tumors of the heart has been attempted. Works dealing with this subject by previous review writers and some additional case reports are presented, with modifications, in tabular form. No new attempts at suggesting an etiology are offered; the actual numbers of these lesions are probably more than one might be led to believe by a count of the cases presented. Usually they are asymptomatic lesions and are benign histologically. When symptomatic,

they may, by newer methods of diagnosis and technical advances in treatment, favorably lend themselves to correction.

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Says Alcoholics Cause Many Auto Accidents

Drunk drivers often are alcoholics, an Ann Arbor psychiatrist suggests.

Writing in the *Michigan State Bar Journal*, Melvin L. Selzer, M.D., says: "A few long overdue studies now appear to implicate the alcoholic rather than the casual drinker" as a highway hazard.

In 1948-49, he notes, nearly half those convicted of drunken driving in Sweden were alcoholics. A Canadian study indicated that a group of alcoholics accounted for two and a half times as many accidents, nine times as many convictions for drunken and impaired driving, and six times as many license suspensions as would be expected in the general driving population.

Several independent studies of personality factors in alcoholics and accident-prone drivers suggest that "auto accidents and the alcoholic personality are often associated," Dr. Selzer continues.

"It appears likely that a substantial percentage of motor vehicle accidents are caused by alcoholic persons. It is also possible that many persons arrested for driving while intoxicated are alcoholic."

Management of Alcoholism in Medical Practice

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THE DISCOVERY of Antabuse and tranquilizing drugs raised our hopes for an effective chemical cure of the problems of alcoholism. To date, however, such hopes remain frustrated. Antabuse had shown no statistical advantage over older treatment methods[1] and was found capable of causing severe physiological disturbance[2] and precipitating psychoses.[3] The tranquilizing drugs have all, without exception, been shown to be addictive, and some more toxic than alcohol;[4-9] so that wisdom of their substitution for alcohol must be questioned. However, there are several reasons why our wish for a miracle drug in this area is so persistent.

1. Alcoholism represents a condition affecting some five million Americans,[10] costing untold damage in manpower and industrial losses.

2. Alcoholics are subject to progressive and severe organic diseases which are difficult to treat, and often irreversible. The unchecked progress of alcoholism is slowly, but inevitably destructive to the addicted individual.

3. Alcoholics have an underlying depressive and suicidal problem; this makes them continue in the self-destructive process. This fact and the patient's need for provoking aggression in his environment makes the treatment taxing and frustrating to the therapist.

Nevertheless, these unpleasant aspects of the problem of alcoholism cannot, despite our wishes, be handled by ignoring them without becoming detrimental to both physician and patient. For while the ingestion of alcohol is the most *conspicuous* aspect of the addiction, the underlying emotional problems are of paramount importance. Only an adequate understanding of them enables the physician to assume the proper medical attitude. To this purpose we shall review both the physiologic and psychologic aspects of alcoholism. The emphasis will be on the practical management of the alcoholic by his physician.

Presented to the Student-Faculty Convocation of Wayne State University, February 1959.

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Acute Complications of Alcoholism

The physician comes in contact with the alcoholic when the patient develops one of the complications of alcoholism. Among them, acute intoxication is a common one. In contrast to the social drinker, who stops drinking when he reaches the elation and freedom from inhibitions that alcohol affords, the alcoholic often goes on drinking to the point of stupor. This overindulgence (which often calls forth righteous indignation) is related to the process of addiction. The alcoholic takes alcohol in an attempt of self-medication for the relief of his depression and anxiety. At first he gets these, but the relief is only temporary. The elation is followed by more intense depression. Some symptoms of the "hangover" may be related to temporary disfunction of the liver. In the alcoholic, however, the overindulgence and relief from depression is followed by an even more intense guilt. The etiology of it is related to the very same basic conflict which keeps him in the throws of his depression. The alcohol addict has intense greed, passive oral and narcissistic striving and an inability to fulfill them because of their infantile nature and the guilt he has attached to them. As a consequence of the guilt, and the self-punishing activities which lead to his alienation of his friends, and relatives, a vicious circle is initiated of repeated use of alcohol, followed by depression and more drug ingestion. Like other drugs producing elation, alcohol gradually loses its potency with constant use. Although the therapeutic index is close to 1 (therapeutic action requiring the amount of drug causing toxic effect) an alcoholic keeps taking it in doses increasing in size and frequency.[11] This may lead to intoxication to the point of stupor, coma, or even death.

The comatose alcoholic requires all the treatment given to any poison-induced coma, for example, barbiturate poisoning, including at times blood perfusion. In the alcoholic, an added problem is the higher likelihood of intracranial injury, which should be kept in mind.

In the alcoholic who is just intoxicated to the point of stupor, the use of intravenous glucose and insulin

is controversial. The currently accepted rationale of the use of insulin with glucose or fructose given intravenously is based on evidence that they seem to accelerate the metabolism of alcohol and its disappearance from the blood. Fructose particularly is attributed on 80 per cent acceleration.[12] There is a danger, however, of precipitating a Wernicke's Syndrome. The alcoholic is usually deficient in thiamine, and the addition of a quickly metabolized carbohydrate further exhausts the co-carboxylases in which thiamine acts. This may lead to the *irreversible* damage which is part of the above syndrome. One would question whether the achievement of faster sobering warrants the risk incurred.

Another complication of the acute alcohol poisoning is the acute excitement state. Under the influence of alcohol, patients may lose self-control, and indulge in random destructive activity. More commonly, however, in the hysterical character, the lessened self-control resulting from the use of a CNS depressing drug puts the patient in danger of break-through of impulses, which he experiences as dangerous. Anxiety and even panic may ensue.

The treatment of pathological intoxication is twofold, and the circumstances, accessibility of the patient and skill of physician will decide the choice of either of the following:

1. *Psychotherapy.*—It is possible to discover the nature of the impulses the patient fears from his productions. They usually consist of a wish-solution of a current problem which, however, comes in too close associative linkage with an infantile, repressed impulse. Without dealing with the infantile neurosis, it is possible to deal with the present conflict and the consequent fear, guilt, remorse, et cetera.

PHYSIOLOGICAL DISTURBANCES FOUND IN DELIRIUM TREMENS AND THEIR POSSIBLE GENESIS

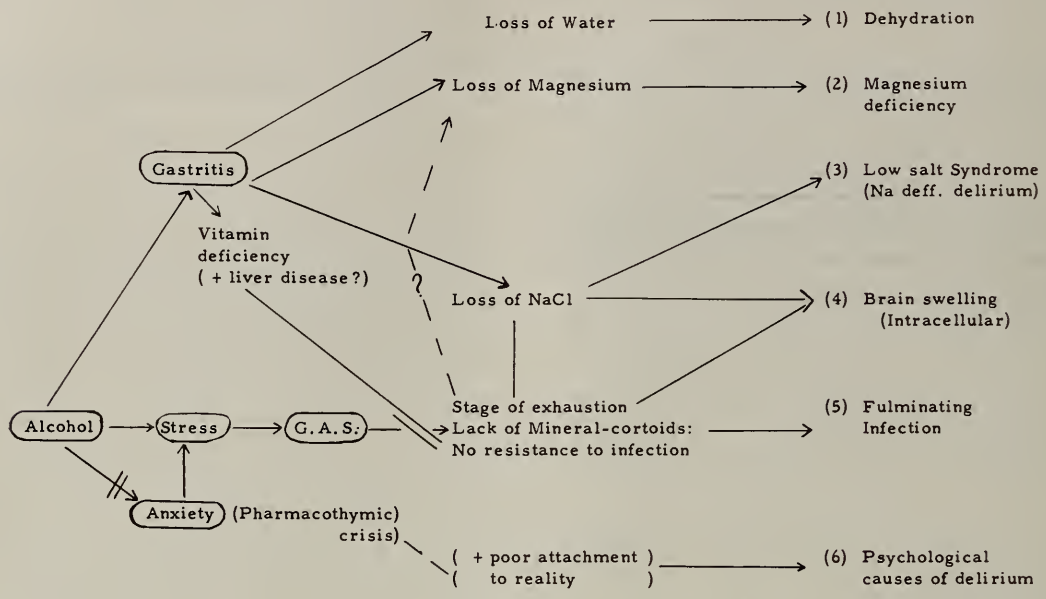


Fig. 1.

2. *More Sedation.*—As in anesthesia, it is possible, and often practical to treat the excitement by induction of a deeper stage of depression of the CNS. Sodium Amytal is the drug usually administered.

The alcoholic often presents himself to the physician with various degrees of tremulousness and anxiety, or ultimately *delirium tremens* (D.T.). A delirium is a state of disturbed consciousness. It may be caused by any chemical, physical or emotional factor which disturbs the metabolism or colloidal state of the brain. The alcoholic may suffer from one (but usually a combination) of the following:[13]

1. Dehydration
2. Magnesium deficiency
3. Sodium and chloride deficiency
4. Brain swelling
5. Fulminating infection
6. Panic state (Pharmacothymic crisis)

Delirium Tremens is the most serious acute complication of alcoholism, and has a mortality of 2-5 per cent.[13] The outcome of the illness depends largely on the physician's understanding of its manifold disturbances and his accurate diagnosis and specific treatment of them. There are several causes of delirium in the alcoholic, albeit ultimately related to the underlying mental illness, or the effects of alcohol (Fig. 2). Probably the most important cause of the delirium is the emotional one. The alcohol addict is in the unfortunate position of having regressed to the oral level of libido organization. This means that, like an infant, he is unable to tolerate frustration, at the same time when he has insatiable, and unfulfillable cravings for affection and admiration. The conflicts, which we are accustomed to look for in the mentally ill, are in the addict in the sphere of passive and incorporative yearnings, which are accompanied by unmolified aggressive impulses. The most basic addiction is the "object-addiction" (as Fenichel calls it), a way to preserve one's object-representations by denying them self-ness and consequently having to get one's love from the "outside." The need for such narcissistic supplies, however, comes to grief because of the original aggression. Through this conflict the alcoholic develops a state of anxious depression. Alcohol becomes his only means of escaping this unbearable state. When the relief is no longer obtainable, the patient is thrown into a desperate state of rage and panic. The resulting crisis creates a physiological stress, and in view of the alcoholic's poor nutritional state, particularly liver disease and vitamin deficiency, may cause an adrenal exhaustion. In itself, the threat of his aggression may be handled by violent action or may precipitate a psychosis (alcoholic hallucinosis when aggression is projected) or cause a delirium. The physiological disturbances observable in delirium tremens vary in intensity. Forty per cent of the patients have gastritis and three-fourths of them have some water and electrolyte deficiency.[13] The most dangerous situations arise when:

1. The combination of electrolyte loss and mineralcorticoid deficiency leads to intracellular overhydration and brain swelling.
2. In the presence of infection: for the same deficiency (paradoxically apparently in the presence of normal hydrocortisone levels) may allow infections to spread uncontrollably.

SYMPTOMS OF THE DISTURBANCES FOUND IN DELIRIUM TREMENS AND THEIR RECOMMENDED TREATMENT

Dx	SYMPTOMS	Rx
Gastritis	—Anorhexia, nausea, vomiting, pain	Ulcer Regime, Vitamins
Water Depletion	—Pinched, grey facies, dry mucus membrane difficulty swallowing, oliguria, hyperthermia	H_2O
Salt Depletion	—Headache, weight loss, weakness, dizziness orthostatic hypotention, fainting, nausea, cramps, blood pressure down, shock	NaCl
Mg. Depletion	—Anxiety, MM Tremors, periferal neuritis, hyperreflexia, vasodilation	$MgSO_4$
Brain Swelling	—Preceded by periferal intracellular overhydration (positive finger-print sign)	
	—Convulsions, generalized spacticity, meningeal signs possibly disturbed vital signs and functions: B.P., Pulse, Temp.	Glycerrhiza D.O.C. C.S.F. drainage (?)
Diminished Resistance to infection	(high fever, toxicity)	Antibiotics
Anxiety	Hallucinations	Paraldehyde (?) Phenothiazine derivatives Meprobamate
	Insomnia	Non-barbiturate hypnotics

Fig. 2.

The above two situations are the most common causes of death in D.T. and account for almost all deaths caused by D.T. directly.

The management of D.T. consists of the following points in order of their importance:

1. Recognition and correction of the water, electrolyte and vitamin deficiencies, including Magnesium.
2. The treatment of gastritis (by the ulcer regime.)
3. In case of infection or impending brain swelling, restoration of salt, and treatment with D.O.C. (Desoxy-corticosterone acetate) or in mild cases, Syrup of Glycerrhiza. Cortisone and related antiphlegistic glucocorticoids are considered contraindicated in D.T.[13]
4. Psychotherapy to reestablish reality-testing, and self-control vis-a-vis one's aggression.
5. Sedation (avoiding barbiturates and paraldehyde), and kindly but firmly refusing the patient's insatiable demands for euphorant drugs.

The last point may require modification in severe cases, particularly in general hospitals. In severe states of panic, the danger of suicide is present, and temporary physical or chemical restraint may be necessary. The importance of sedation, however, is commonly exaggerated, and its dangers underestimated. Excessive sedation of the D.T. patient may mask the signs of physiological disturbances which may become lethal. For instance, it may entirely mask the early signs of brain swelling, especially since it is often manifest early in convulsions—and the sedative drugs are anticonvulsants. The delay in *specific* treatment of the low-salt state and adrenal exhaustion may cause the patient's death.

The problem of convulsions in the alcoholic requires special attention. Alcohol itself (plus the rage of the individual) or the withdrawal of alcohol may result in seizures.[19] About 10 per cent of D.T. patients have convulsions in the absence of intracranial hemorrhage. A frequent and important cause of convulsions in D.T. is the use of barbiturates (often self-medication) prior to the onset of D.T. to allay the "shakes." This type of patient is being withdrawn from alcohol and barbiturates simultaneously. In such cases, the barbiturates should be withdrawn gradually. Already mentioned was another cause of convulsions: the periventricular, periductal and mammilary bodies necrosis due to thiamine deficiency: Wernicke's Syndrome. This condition is often accompanied by ataxia and cranial nerve palsy.

The convulsions in the alcoholic should be distinguished from hypoglycemic states, another complication of alcoholism which is secondary to liver cirrhosis. Ordinarily they are precipitated by hunger, exercise or excitement, and do not develop the full blown grand-mal convulsion. The clinical picture, however, is less reliable in the differential diagnosis than the relative regularity and the presence of anxiety that often marks the onset of the hypoglycemic states.

We shall not discuss the consequences of severe liver cirrhosis, which are complex and are best exposed in other connections. It must be stressed, however, that the physician who treats an alcoholic must be conscious of the manifold implications of the disturbances of liver function. Much as we wish it, the simple expedient of Vitamin B-Complex and liver-extract shots, which many alcoholics receive for years, does not solve this serious problem.

The vitamin deficiency, however, does sometimes manifest itself in peripheral neuritis, and replacement therapy is specifically indicated there. Recent work has demonstrated another cause of peripheral neuritis in the alcoholic: magnesium deficiency.[15,16] The symptoms of magnesium deficiency, like that of calcium, are related to its concentration in the blood in an ionized state. The alcoholic suffers hypomagnesemia because of nutritional, hormonal, and possibly liver function disturbances.[13] The neuritis caused by hypomagnesemia appears suddenly and equally quickly responds to intramuscular magnesium restoration.

Chronic Complications of Alcoholism

In this category, the most conspicuous complication lies in the field of diffuse brain damage. Probably a cumulative effect of repeated Wernicke's acute necrotic attacks, it results in rather widespread brain tissue destruction. The functions lost or impaired involve not only those of the intellect such as memory judgment, and conation, but an affectual blunting and insensitivity. The poor reality testing and other previously described character problems now manifest themselves in a total lack of responsibility and denial of illness. This is noticeable in the confabulatory attempts to cover up the amnesia. Thus the Korsakoff's "psychosis" results in the inability of the patient to take care of himself. Unless family care is possible, it is necessary to place the patient in a nursing home for the rest of his life.

Another equally serious chronic complication of alcoholism is the social deterioration. The long descending spiral of guilt and self destructive activities deprives the patient of all self-respect, as well as social contacts and family relations. The patient ends up as an out-

cast, a bum, a "skid-row character." Fortunately, unlike the irreversible brain damage, this complication is subject to rehabilitation. Centers are now available in which the stress is laid upon the restoration of the patient's hope and self-esteem. The effort to help this type of an individual must begin with the provision of shelter and a job. This alone, however, is not enough. When the alcoholic is given just "another chance" without other, more basic help, he will often repeat the malignant pattern of self-destructive activities. When this type of an individual is worked with, one uncovers underneath the frozen mask of the "skid-row bum" a severe depression. Seemingly paradoxically, when help is given, the patient may display overt suicidal behavior. The rehabilitation therefore, after attending to the basic needs of the individual, must deal with underlying emotional problems.

Nature of Emotional Illness in the Problem Drinker

Any generalization in medicine, particularly in psychiatry, results in distortion of the facts. I have been guilty of many such generalizations in the above discussion, and I cannot correct only the most essential one. All the references to the emotional illness of the problem drinker were to the "alcohol addict," that is, where the basic problem is of a "pharmacothymic personality"[17] or "oral character," the terms being attempts to name the basic conflicts of the individual who has regressed to the libidinal development of the oral level. However, self-medication with alcohol may be used for the relief of psychic unpleasure such as anxiety or depression resulting from a variety of syndromes. The nosological entities (each itself a generalization with limited usefulness) described leading to problem drinking include obsessive-compulsive neurosis,[18] schizoid characters,[19] phobias,[20] and a number of other emotional problems.[21]

Even in the addict-oral-character syndrome there is a variety of factors (the patient's assets) such as ego ideal, ability for sublimation and work et cetera, which modify the outlook for the patient's ability to succeed in psychotherapy. Of crucial prognostic import is the patient's ability to form stable object relations. The intensity and controllability of depressive and destructive trends have to be evaluated. The variety and complexity of factors involved makes it difficult for the medical practitioner to evaluate and decide on the optimal method of management of the problem drinker. For this reason, it is often expedient to refer such a patient to a psychiatrist or an alcoholic clinic.

After the evaluation of the assets and capacities of the patient, as well as recognition of the type of problem which underlies the addiction, a decision can be made concerning the expected optimal type of management. At present, this evaluation constitutes only a working hypothesis on the basis of which a therapeutic trial is made.

A few questions came up in this connection. Firstly: What is the role of Alcoholics Anonymous in the management of the alcoholic? The A.A., and some similarly oriented agencies, offer a type of group therapy which is mainly effective by reinforcement of prohibitions, by inspiration, religious activity and group effort. The alleviation of guilt is attempted. A good number of alcoholics who do not qualify for uncovering therapy can be helped by this program. There is a sizable number of them, however, who cannot stay with the A.A. for a variety of reasons. In fact at present, only 4 to 6 per cent of the alcoholics remain active in A.A. It is therefore imprudent to insist on referral to A.A. as a universal disposition.

The question of hospitalization comes up often. The hospital treatment of the *underlying emotional problem* is only successful in about one-third of the cases,[22,23] and when enforced, poses the risk of precipitation of psychoses in some cases.[22] There are certain aspects of alcoholism which are best treated when the patient has to deal with the very reality which causes him difficulty. Commitment in a State Hospital for long term treatment should therefore be reserved primarily for patients who show gross aggressive or self-destructive behavior, or other special personal or social problems necessitate the removal of the patient from the community.

The physician who refers an alcoholic for treatment to a psychiatrist or alcoholism-treatment clinic should keep in mind the following aspect of alcoholism which he will recognize as no different than those found in some other illnesses:

1. *Alcoholism is a condition characterized by relapses.* The psychotherapist, family of patient and the referring physician must be prepared for this. As a matter of fact, the duration of abstinence is only a partial and rather inaccurate indicator of the progress of the treatment. The problem-drinker's progress is better evaluated by the status of his emotional, social and industrial adjustment. The referring physician who is mindful of this can help his patient; for his encouragement may be needed to return the

patient to psychotherapy after a relapse of drinking, depression, anxiety or self-destructive behavior.

2. *Some alcoholics present a problem simulating an organ deficiency disease.* Although no specific under-developed organ can be isolated, many alcoholics act as though they failed to develop that agency of the mind which is capable of dealing with everyday reality. Such a person, like a diabetic, needs lifelong support, whereby this deficiency is supplemented by the therapist's efforts. The implication of this aspect of alcoholism then is in some patients of a long term (sometimes life-long) contact with an alcoholism clinic, rather than an abrupt "cure."

Summary

The physician cannot avoid dealing with alcoholics. He must encounter them in industry and his practice. Unless he is prepared with proper insight, the physician must fall prey to cynicism or hostility toward the alcoholic patient. The current discussion, though not always optimistic, represents an attempt to suggest ways of practical humane management of the alcoholic by his physician.

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Fatal Case of Eczema Vaccinatum

The author reports on an unvaccinated two-year-old girl who had had infantile eczema since she was three months old and in whom a vesicular eruption had appeared on the legs and had spread to the arms and face four days before she was admitted to hospital. Ten days before the child's admission to hospital her younger brother had been vaccinated. The history of atopic eczema and of contact with a recently vaccinated sibling, the distribution and characteristics of the rash, and the course of the illness were typical of eczema vaccinatum. The patient died on the twelfth hospital day. The vaccinia virus was isolated from specimens of skin and organs obtained at autopsy. The skin of candidates for vaccination should be examined carefully, and no one with significant skin disorder should normally be vaccinated, although in a smallpox outbreak balanced assessment of the relative risks has to be made. Before vaccination a careful history should be taken for evidence of skin disorder in the family or immediate environment, and no close contact with those with skin disorders should be allowed for twenty-one days afterwards. Reactions should be covered to prevent accidental contamination of others.—*Lancet*, London, Sept. 24, 1960.

Cesarean Stillbirths

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AN OLD MAXIM of obstetrics is "Never do a cesarean on a dead baby." Of course, this dates back to the days before the free use of blood, antibiotics, and modern surgical technique. Now cesareans are performed more frequently, and part of this increase is due to the wider fetal indications for intervention. However, when the baby is known to be dead the only indication is a maternal one and so one might expect cesarean stillbirths to be unchanged in frequency.

Has there actually been any change in the frequency of occurrence? Also, are postoperative complications such as infection and ileus more common when the baby is dead? And what about the advisability, even today, of doing a cesarean on a known-dead baby? Could some of these fetal deaths be avoided? Previous studies found by the author[1-6] have been concerned with total fetal mortality at section (perinatal mortality) and have not given great detail about cases where the fetus was known to be already dead.

In an effort to investigate this problem, the author has reviewed the records of two Detroit hospitals and has been able to find thirteen cases of cesarean section where the baby was known to be dead prior to surgery. There were also four other cases where the fetal heart was present but slow, prior to surgery but the baby was stillborn (Table I). In one hospital, the period studied was from January 1, 1954 to June 30, 1959, and in the other from January 1, 1956 to September 30, 1959. The number of sections and stillbirths (for cesareans only) is given in Table II. The number of cases appears to be too small to draw any conclusions about variations in the cesarean stillbirth rate.

TABLE I. SURVEY OF CESAREAN STILLBIRTHS IN TWO DETROIT HOSPITALS
(17 Cases)

Patient	Date	G-P-A	Age	Indication For Section	Previous Pregnancies	FHT Present Before Surgery	Duration of Pregnancy	Morbid
1. Mrs. J.A.	July 58	1, 0, 0	25	Abruptio with shock		No	5 mos.	Yes
2. Mrs. M.T.	June 56	6, 4, 1	37	Repeat	Rh. Last pg. praevia	No	9 mos.	No
3. Mrs. D.H.	Nov. 57	3, 2, 0	40	Ruptured uterus	2 prev. sections	No	8½ mos.	Yes
4. Mrs. M.E.	Dec. 57	4, 2, 1	25	Repeat (diabetic)	2 prev. sections	No	8 mos.	Yes
5. Mrs. P.M.	Aug. 57	1, 0, 0	17	Abruptio with shock		Yes (slow)	8 mos.	Yes
6. Mrs. I.I.	Apr. 57	1, 0, 0	27	Abruptio with shock		Yes	8 mos.	Yes
7. Mrs. V.N.	Feb. 59	1, 0, 0	25	Fetal dist. +praevia		Yes (slow)	9 mos.	No
8. Mrs. D.B.	Sept. 54	3, 2, 0	29	Repeat	Rh. Last baby died	No	7 mos.	No
9. Mrs. R.C.	May 54	1, 0, 0	20	Abruptio with shock		No	6 mos.	Yes
10. Mrs. L.C.	June 58	6, 4, 1	38	Repeat+abruptio	Abruptio last pg.	No	7 mos.	No
11. Mrs. E.M.	Mar. 58	2, 1, 0	33	Abdominal preg.	Normal	No	9 mos.	Yes
12. Mrs. M.F.	May 59	6, 5, 0	36	Abruptio with shock	1 (small) prev. abr.	No	8½ mos.	No
13. Mrs. J.S.	June 59	4, 3, 0	24	Central praevia	Normal	Yes	8½ mos.	No
14. Mrs. G.K.	Mar. 57	2, 1, 0	30	Repeat +new diabetic	CPD—first section	No	8 mos.	Yes
15. Mrs. E.W.	Nov. 56	6, 5, 0	33	"Flying fetus"—Rh.	2 prev. stillborn	No	7 mos.	No
16. Mrs. E.W.	June 59	7, 6, 0	36	Repeat	See 15 above	No	8 mos.	Yes
17. Mrs. G.C.	Sept. 59	1, 0, 0	34	Complete abruptio		No	7 mos.	Yes

Next, in regard to maternal morbidity, we find that in the thirteen cases where the baby was known to be dead prior to section, eight of the mothers were febrile postpartum. This was compared with the morbidity of the last 100 cesareans performed at one of the hospitals (Table III). It can be seen from this



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that stillbirths are associated with an increase in post-partum morbidity. Probably this would have been more marked if the fetuses had been dead for a longer time. The maximum time between fetal death and section was about four days in this series.

There were four cases (numbers 5, 6, 7 and 13) where the fetus was alive but in poor condition prior to surgery. The first two were severe abruptios at thirty-six weeks of gestation admitted with a tense painful uterus, vaginal bleeding, a long closed cervix, and a normal blood pressure. The other two were admitted with painless vaginal bleeding; x-ray in both was compatible with placenta praevia. Stillbirths such as these are often non-preventable because perfect timing is difficult to achieve. Perhaps a change of policy allowing sections to be done in the delivery suite would save some of these babies (both hospitals now schedule sections only in the operating room). As can be seen from Table I, the largest group of known stillbirths is comprised of abruptios (five cases). When the cervix is unfavorable for vaginal delivery and the bleeding is severe, section is often resorted to for maternal reasons—to prevent further hemorrhage and possible defibrination.

TABLE II. SURVEY OF CESAREAN STILLBIRTHS IN RELATION TO ALL CESAREAN SECTIONS IN TWO HOSPITALS

(Detroit, Michigan)

Hospital	Cesarean	1954	1955	1956	1957	1958	(1st 6 mos.) 1959
A	Sections	91	105	117	137	138	54
	Stillbirths	2	0	1	4	1	2
B	Sections	—	—	82	87	82	31
	Stillbirths	—	—	1	1	2	3

TABLE III.

EFFECT OF STILLBIRTH ON CESAREAN MORBIDITY

	Post-Partum Morbidity		
	Present	Not Present	Totals
Stillborn infants	8	5	13
Liveborn infants	14	86	100
Totals	22	91	113

Chi-square 15.8—probability close to .001.

Morbidity defined in all cases according to the standard of the American Committee of Maternal Welfare.

Another four stillbirths were caused by erythroblastosis, and in two of these, section may not have been necessary. Mrs. M.T. (Case 2) was a thirty-seven-year-old (G6P4A1) whose first three children were delivered vaginally (the third was stillborn and erythroblastotic at term). Her fourth pregnancy terminated at seven months by section because of placenta praevia—a 3-pound stillborn. She was admitted at thirty-seven weeks of the present pregnancy —not in labor, with no fetal movement for two days, and a classical section with tubal ligation was performed. The next case (Number 15) was a thirty-three-year-old (G6P5A0) whose second, fourth, and fifth children were stillborn (all vaginal deliveries). She was admitted at thirty-three weeks of her next pregnancy with no fetal movement for the preceeding two days and x-ray revealed a "flying fetus" (Fig. 1). She was sectioned and had an uneventful convalescence. She was then readmitted (Case Number 16) three years later at thirty-six weeks of gestation again with a dead erythroblastotic fetus and not in labor. She was sectioned, tubal ligation was performed and she was discharged in six days. However, she was readmitted three days later with intestinal obstruction, left subdiaphragmatic and bilateral pelvic abscesses, acute peritonitis, and acute endometritis. The following surgery was performed: lysis of adhesions, drainage of the abscesses, colotomy and cecostomy, ap-



Fig. 1. "Flying Fetus." The original x-ray clearly shows gas in the fetal heart, aorta, and aortic branches. The elbows are back and up, and the thighs partially extended with the knees flexed.

pendectomy, supracervical hysterectomy, and right salpingo-oophorectomy. The uterine incision had separated and this was thought to be the source of the severe infection, from which she finally recovered.

One more case should be mentioned: abdominal pregnancy. Mrs. E. M. (Case 11) was a thirty-three-year-old (G2P1) who was admitted at term in labor. She had undergone laparatomy at two months' gestation for a suspected ectopic pregnancy at another hospital but nothing was found. X-rays now revealed a transverse presentation and so laparotomy was again performed, and an intraligamentous pregnancy was discovered, the placental sac apparently lying between the leaves of the broad ligament on the left, and the uterus was empty. This probably represented a tubal abortion which succeeded in re-implanting itself. She had a difficult and prolonged convalescence.

Summary

1. Seventeen cases of cesarean stillbirths were reviewed. No conclusions can be drawn about variations in the rate of occurrence because of the rarity of this condition.

2. Maternal postpartum morbidity appears to be increased when the baby is dead prior to section.

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Reasons for High Family Spending on Health

Families with heavy expenditures for health are generally larger in size and have higher incomes than average, and a higher-than-average proportion of their health spending is covered by voluntary health insurance.

These findings were reported by Health Information Foundation in its monthly statistical bulletin, *Progress in Health Services*. They come from a recent survey of 2,941 families, representing a random cross-section of the United States, conducted jointly by the Foundation and the University of Chicago's National Opinion Research Center.

Almost one-third of the surveyed families—31.6 per cent—reported annual spending of $300 or more for all personal health services, such as physicians' and dentists' charges, hospital care, drugs, private-duty nursing, eyeglasses, and appliances. In this high-spending group, 47 per cent spent between $300 and $499, 38 per cent between $500 and $999, and the remaining 15 per cent $1,000 or over.

The entire group of high-spending families, the Foundation said, accounted for about three-fourths of all private expenditures on health—$12 billion of the $16.2 billion spent by the American public for this purpose in the survey year of 1957-58.

Among other findings about high-expenditure families reported by the Foundation:

The incomes of high-spending families were usually above average. For example, only 18 per cent of the families spending $1,000 or over had annual earnings of less than $3,500, against a comparable 34 per cent of all families.

High-spending families were larger than average in size. Whereas 44 per cent of all families consisted of two persons or less, only 31 per cent of the $1,000-and-over group were in this category.

High spenders required considerably more physicians' services (particularly surgical) and hospital care than average. Among all families the average annual expenditure on physicians and hospital care came to $98 and $68, respectively, while the comparable figures for all high spenders ($300 or more on all health items) were $231 and $195. Surgical bills alone averaged $19 for all families and $57 for the $300-and-over group.

Voluntary health insurance coverage was especially prevalent among families spending $1,000 or more; 88 per cent of them had such insurance, against 69 per cent of all families. The insured $1,000-and-over families had an unusually high proportion of their total expenses covered by their insurance—35 per cent, against only 24 per cent for all insured families.

Commenting on this finding, George Bugbee, Foundation President, pointed out that "Voluntary health insurance was originally devised to cover primarily costs of hospital care and surgery." As a general premise, he added, "the emphasis on hospital-surgical coverage was sound," since the relative importance of these two items in the family health bill becomes greater as total spending increases.

Submarine Medicine

Captain Joseph Vogel, MC, USN
New London, Connecticut

SUBMARINE medicine is a military medical specialty which encompasses all phases of human underwater activity. It is essentially a form of preventive occupational medicine concerned with the medical problems of man in his attempt to penetrate, survive, and perform beneath the surface. Submarine medicine includes the field of diving, as well as life aboard submarines, and perhaps should be more properly called "underwater medicine."

This specialty had its beginnings in the U. S. Navy over a quarter of a century ago. Official recognition of these specially trained medical officers was established during World War II, with authority for those qualified, to wear a special insignia, the submarine medical officer dolphins. A division of submarine medicine was established in the Bureau of Medicine and Surgery over a decade ago. The training for those volunteer medical officers selected has changed considerably to keep pace with the advances in the operational capability of the submarine, as well as with the evolution of new types of underwater swimming equipment.

The rapid expansion of the nuclear powered submarine fleet, coupled with the decision by the Naval Reactors branch of the Bureau of Ships to assign a submarine medical officer to each of these new submarines for at least a year, has resulted in a concentrated effort to make known to young medical officers the fine opportunities in this field. The first of these who were assigned to the USS Nautilus, Seawolf and Skate, as well as other recently commissioned nuclear powered submarines, were given a broad, comprehensive training, which included a year of postgraduate study in radiobiology, a special course under the auspices of the Armed Forces Special Weapons Project, and six months' training at a Reactor Site. All of this, in addition to the regular six-month course in submarine medicine conducted at the Submarine Base, New London, and the Deep Sea Diving School, Naval Gun Factory, Navy Yard, Washington, D. C.

The opinions or assertions in the article are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

The rapidity with which new submarines are coming down the ways has forced a streamlining of this lengthy training to a six-month program, sufficient in scope to qualify the medical officer for this type of duty. There are four doctors in this training at the present time. The longer course is still available, but assignment to it is based on the personnel needs of the service. A third modification of the training plan is made for medical officers who will be assigned conventional submarine squadrons. This modification includes the Deep Sea Diving School course. The initial six weeks of training is given at the Submarine School, Submarine Base, New London, where along with the regular line officer students, the doctor is taught what a submarine is, what makes it operate, and other characteristics of this type of warship. The purpose of this is to provide the medical officer with a background in basic submarine operations and a familiarity with some of the technical material in the support and understanding of, submarines and submarining.

To be considered qualified and wear the medical dolphins, the medical officer, having completed his course of training, must serve a year in the field, successfully pass a written examination given by the Central Board of Submarine Medical Examiners, and write an acceptable original thesis on some medical aspect of submarines or diving. Several types of assignment are available to the submarine medical officer following his tour of duty with a submarine or diving activity. These career possibilities encompass all clinical medical fields.

Machines are developing at a pace which is more rapid than the ability of the human to manage them with safety. The design and operational success of the nuclear powered submarine can be cited as an example. This man-machine complex has a far greater endurance potential than the crew which operates it. This is even more true of the space ship. A submarine is, in effect, a space ship, differing mainly in the element which surrounds it and the velocity with which it travels. The similarity of problems of the two resulted in the First International Symposium on Submarine and Space Medicine, held at the Submarine Base this past fall. The subject matter was limited to physiological

problems of human ecology in confined spaces.

Experience with conventionally powered submarines raised the problems of human tolerance to carbon dioxide and hypoxia. The greatest part of our research effort was directed toward obtaining answers to these. In 1953, the first large scale controlled experiment on human confinement was accomplished by the Submarine Medical Research Laboratory at New London. This was Operation Hideout, in which twenty-three volunteers were submerged in a submarine alongside the dock for a period of sixty days. There were five phases to this experiment. First, an initial period of laboratory testing of the volunteers for thirty-five days; second, exposure to atmospheric air within the submarine for the first nine days; third, exposure to 1.5 per cent carbon dioxide in the submarine for forty-two days; fourth, exposure to atmospheric air in the submarine for nine days. The fifth phase consisted of final laboratory testing.

Time will not permit an extensive discussion of all the tests made. However, a summary of the findings relative to carbon dioxide revealed that the concept of prolonged exposure to 1.5 per cent CO_2, heretofore accepted as safe, manifested certain undesirable physiological effects. These results constituted the basis for the design of the carbon dioxide scrubber presently used by our nuclear powered submarines, which maintains carbon dioxide levels below 1 per cent.

Present methods of selection give a predictive validity in the range of .50 to .60. In anticipation of the mission for the Polaris Missile Firing Submarine which will involve periods of submergence at sea in excess of the sixty-day record submergence of the USS Seawolf, a slight change in focus of the research in selection techniques is planned. A recent pilot study examined the relationship of Autonomic Nervous System Reactivity and ratings with respect to traits related to emotional stability and temperament. It showed that the characteristic level of skin conductance, as well as the recoverability-after-stress, may be predictive of the ability to withstand stress, and seems correlated with certain temperamental traits. Further studies will be coordinated with those planned by the Physiology Branch, utilizing a new and unique laboratory tool, a fully climatized pressure-altitude chamber, now being constructed. These physiological studies of human ecology in confined spaces will be outlined later on. Another aspect to be investigated by the assessment group will be "motivation." Results of studies on initial motivation to volunteer for submarine duty have revealed that status, the opportunities for technological training, and additional pay, in descending order of importance, are in the main the motivating forces for the enlisted man; officers exceed enlisted men in respect to "need for achievement" and "need to dominate." It is believed that the problem of maintaining this initial motivation will be one which is worthy of intensive study in the operations of our Fleet Ballistic Missile Submarine. This weapons system will be one of the greatest deterrent forces in the prevention of an all-out war. Because it is a deterrent, a successful mission is one where missiles are not fired and the submarine is not detected. From experiences in World War II, we know that the motivation and morale of the crews of our submarines were highest when the submarine had contact with the enemy and carried out successful operations against him. Think of the situation of the officers and crew of the Fleet Ballistic Missile Submarine, where for extended periods they are completely isolated from their families and the world, with little to do but sit in the depths of the ocean and wait for a signal which we hope will never have to be sent.

Pilot studies in stress and fatigue have also been done, and future plans will include the study of monotonous tasks and vigilance.

Rapidly, I would like to outline the planned studies in physiology mentioned previously. These studies are aimed at resolving some of the problems raised by the question, "What is man and what is nature?" The answers to these would enable us to provide the engineer with specific information so that he could plan and build a satisfactory environmental control loop. In a closed space like the submarine or space ship, a number of factors are artificially introduced into the environment. This technical environment contains atmospheric impurities and trace substances not normally present in our surface environment, and which change in accordance with the technical equipment used in these spaces. In conventional submarines there is a 10- to 20-fold increase in the number of positive and negative ions during submergence. The Control Room had the highest number of ions resulting from the gamma radiation originating on the multitude of radium painted dials. In most instances a predominance of positive ions was found. In view of the recent accumulation of evidence of deleterious effects resulting from exposure to an atmosphere with a predominance of positive ions and a reversal of this by a change to negative ion preponderance, this subject is worthy of further investigation. The Laboratory plans to start initially with animals, then follow up using human subjects.

Another concept to be investigated is the physio-

logical diurnal-nocturnal cycles or rhythms. These endogenous mechanisms in man are influenced to a great extent by those external time-givers in a natural environment, such as light and darkness, temperature, humidity, barometric pressure, et cetera. What will be the consequence of a monotonous environment and arrhythmical processes produced by the necessities incident to the operation of man-machine systems? It has been shown that animals can adapt their endogenous cycles to an artificial day increased to 28 hours or decreased to 21 hours, but, the endogenous cycles become independent of external cycles if this artificial day exceeds these limits. To what extent man can similarly adapt is not known. If adaptation is not possible to the artificial day in the technical environment, a dissociation of the organism and environment would undoubtedly come about. It follows that man must adapt to the technical environment to retain the constancy and equilibrium of his milieu interieur, or we must adapt a technical environment to those natural principles embodied in man in order to preserve this homeostasis.

The physiological significance of nitrogen under conditions of prolonged exposure in this technical environment will be considered. It is probably not limited only to the prevention of atelectasis from the absorption of alveolar gas. The imitation of natural cycles of light, temperature, humidity, barometric pressure and ionization in closed systems will be investigated. It seems environmental time-givers are essential for the synchronization of the inner physiological cycles with the environmental time scale. It has also been shown that one of the earliest signs of a pathological process in an organ is the change or loss of its endogenous cycle. Neglect of the role of cycles has been demonstrated to impair work performance in shift-workers.

Decreased energy expenditures resulting from living in confined spaces has both psychological and physiological implications. Recent experiences with a commercially manufactured machine which causes muscular contractions through electrical stimulation, and used by personnel aboard the USS Sea Wolf, has shown certain beneficial effects, aside from cosmetic. Controlled studies on this will be undertaken at the Laboratory.

I have deliberately avoided any discussion of the radiation question on our nuclear powered submarines. This, for the reason that very careful monitoring reveals the shielding is so adequate and carefully planned that crew members are subjected to less radiation than we are here on the surface. More important than the radiation has been the presence of various trace substances as contaminants in the atmosphere of this closed space. To mention some of these: the by-products of human metabolism given off by the body, such as urea, hydrogen sulfide in perspiration, and flatus gases; atmospheric contaminants released as a result of food preparation; paints, and solvents. It is interesting to note that the hydrocarbons released in the atmosphere from paints have resulted in a regulation which forbids painting within the nuclear submarine for a considerable time prior to prolonged submerged cruises; Aerosols, such as Freon from refrigeration lines, substances released in the atmosphere from heated insulating materials. To summarize, every component in the interior of a submarine is a potential source of contamination. Toxicology studies done heretofore are mostly useless when applied to life aboard a submerged craft. These studies are based on an eight-hour exposure for a forty-hour week, and we are faced here with a twenty-four-hour exposure which can extend for months.

There is also the question of the interaction of these contaminants—synergistic, additive or antagonistic. Humidity and condensation droplets are also factors to be looked at more closely. Investigators have demonstrated that 47 to 90 per cent of airborne droplets are removed from the inhaled air and retained in the respiratory tract. Condensation nuclei increase water condensation in the respiratory tract, which facilitates the precipitation of particles and impurities in the air. Thus, toxic substances which might be in the air in sub-threshold concentration could be concentrated in the condensed water droplets and reach toxic concentrations when precipitated.

Time limitation has permitted only a résumé of some of the problems and subjects which are of importance to us concerned with human ecology in confinement. In World War II, the Submarine Force constituted 7/10 of 1 per cent of our combat naval forces. This small group accounted for 55 per cent of the Japanese shipping losses—some 5½ million tons of it. The mission of the Submarine Medical Service is to maintain the living, working, and fighting conditions in these unnatural environments and unusual atmospheres safe and habitable under the increasingly difficult operational demands. We accept this challenge as a great opportunity for the medical profession to broaden its understanding of "what is man, and what is nature?" and we welcome your participation in this mission. We are striving to ensure that the faith and trust that our nation has placed in the Submarine Force will be fully justified.

Needed Federal Legislation

A new year has started. A new administration is in office with many ideas in opposition to the prevailing program of the past years. A new Congress is in session, and all Bills which had started and were in progress must be reintroduced. If they did not pass, they are dead legislatively. There are many activities in which the medical profession is and should be supporting and urging passage thus taking a position "for" instead of the traditional appellation the profession has received for many years of always being "against."

The so-called Keogh Bill passed the House and died in the Senate this past term. This Bill provides that self-employed persons, professional and others, may secure some of the benefits granted to their friends and neighbors who are in industry or salaried positions. Industry is allowed and urged to set up, before taxes, retirement funds to take care of their executive and administrative officers after they have retired. This is as it should be because about a quarter of a century ago the government in its great wisdom provided for compulsory retirement at a fixed age, in most cases long before those people would have retired. Nothing was done about the self-employed, professional and other people to allow a similar provision so that they could build up reserves before taxes for retirement. Simple justice should provide that the self-employed be given a similar privilege.

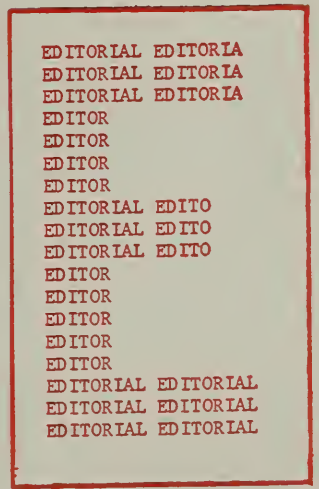
The Keogh Bill was a step in this direction, however, but nowhere near as adequate as the provisions now in force for industry and salaried workers. This Bill should be reintroduced and the profession should again support it. As common justice, it should be enacted into law.

Social Security

The Social Security Act needs some amendment. It provides that the retired person forfeit his security payments if he earns more than $150 a month. The Kerr-Mills Bill provided this. We believe this restriction still is unjust and should be removed. For most people who have been earning a reasonable income the Social Security benefit at retirement plus the limited earnings (not to lose the Social Security benefits) makes a very inadequate income to live on and support a man and his wife. This restriction should be completely removed.

Compulsory Retirement

Many leaders in the profession have believed for years that retirement is a serious handicap and threat to the good living and health of elderly people. Studies universally support this idea. The Michigan State Medical Society took official notice of this health item in a



conference last April at which a set of principles was adopted leading to the recommendation for the abolishment of compulsory retirement. The AMA, at the June session at Miami Beach, also adopted a resolution calling for a change in the laws requiring a fixed age of retirement.

Medical Care

We are on notice by President Kennedy, by the Democratic Party platform, and by speeches of innumerable candidates that the old age beneficiaries of Social Security *will be cared for through Social Security* in the matter of hospital and medical services. That provision was attempted at a rump session of Congress but failed. Other Forand type proposals also failed. The Mills Bill, after certain changes and provisions, was supported by the American Medical Association and passed into law. It provides that old persons, regardless of Social Security eligibility, may be cared for under voluntary insurance or government-sponsored care under the welfare departments of the state, providing their income is within certain limits which demand help. The government will help by providing certain contributions to this aid.

That Bill is now in effect. This money comes through general taxes, half federal and half state. The total amount will be remarkably small ($100,000,000) because this does not include self-supporting or adequately situated persons—only those on restricted income. This is the same group of senior citizens the American Medical Association "resolved" about December 1958 at Seattle and the Blue Shield programs have been serving for more than two years. Millions of these oldsters would not be eligible for the Forand type program because they never had Social Security. The Mills Bill and the state bills which support it are not perfect, they will need study and modification to make them entirely acceptable. All these items the medical profession can support. The profession and the public are on notice from the new administration that attempts will be made immediately to put all this old age medical care into the Social Security program and "without increase of taxes."

Incidentally, this Social Security program is a tax and a rather unjust one, if medical care for the aged is to be placed under it. This tax is compulsory and is deducted from wages and salaries before payment for everyone covered earning up to $4,800 a year. All salaries and wages above $4,800 a year are exempt in this category. The low salaried—low income people —will carry the big burden, rather than the high income folks who could better afford an extra tax.

This particular tax has no exemption before it is assessed. It is a primary tax on the lowest wages and incomes. The general tax laws have an exemption of 20 per cent for the lowest item and a sliding scale exemption for all other income in addition to wages and salaries. Social Security tax is on earned income only.

Wayne Honors John M. Dorsey, M.D.

A new concept in higher education was announced by the Board of Governors of Wayne State University at the monthly meeting, December 14, 1960.

Named "University Professor" was John M. Dorsey, M.D., internationally prominent psychiatrist. A five-year grant of $110,000 from McGregor Fund will support the new program which begins February 1, 1961.

Doctor Dorsey, sixty, will leave the chairmanship of the psychiatry department at the College of Medicine to assume his new duties.

As outlined by Doctor Hilberry, the University Professor is attached to no specific department.

"A few other universities have experimented with this general concept freeing individuals to work in the broad fields of concern to them but none, so far as is known, has named a man with responsibility to be and to represent the "generalist" for the whole academic community. This venture should pay enormous rewards and will be watched with keen interest across the nation.

"The University Professor is a man with the creative gift of seeing knowledge, not in pieces, but whole—as nearly whole as is possible in these days. He may teach a limited amount of regular credit courses . . . which would serve a wide usefulness to the student body. The University Professor will be available for informal contacts with students and faculty, for bringing his wide reading and his own creative work to bear on the life of the campus. He will also be responsible for bringing to the campus, for lectures and visits, men who can represent to the student body the values of 'wholeness of vision.' "

Dr. Dorsey received his B.A., M.S. and M.D. degrees from the Iowa State University. He studied at the University of Vienna during two years of post-graduate study as a fellow of the Rockefeller Foundation. During this period, he worked with Professor Sigmund Freud, in addition to studying neuroanatomy and neuropathology. He was on the staff of both the University of Michigan and Iowa State University where he taught psychiatry.

MCI—March 8, 9, 10, 1961

In this issue of THE JOURNAL, members will find a most interesting program for this year's Clinical Institute.

Michigan Clinical Institute

Refresher Course

Sheraton-Cadillac Hotel, Detroit

WEDNESDAY-THURSDAY-FRIDAY, MARCH 8-9-10, 1961

Milton A. Darling, M.D., Detroit,
General Chairman

Every member of the Michigan State Medical Society is invited — urged — to attend the 1961 Michigan Clinical Institute. Once again, it will be held in Detroit at the Sheraton-Cadillac Hotel.

This excellent refresher course will begin Wednesday, March 8 and end on Friday, March 10, at noon.

The total program has been planned to help the practicing physician in his daily work.

Information

- **HEADQUARTERS** — Sheraton-Cadillac Hotel, Detroit; Assemblies and Exhibits on Fourth Floor; News Room on Fifth Floor (Michigan Room)

- **REGISTER**—Fourth Floor—as soon as you arrive. Hours: Tuesday, March 7: 1:00 to 5:00 p.m.
 Wednesday, March 8: 7:45 a.m. to 5:00 p.m.
 Thursday, March 9: 7:45 a.m. to 5:00 p.m.
 Friday, March 10: 7:45 a.m. to 1:00 p.m.

- **NO REGISTRATION FEE** for Members of MSMS and other State Medical Associations, AMA, and Canadian Medical Association.

- **ADMISSION BY BADGE ONLY** to all Assemblies, Discussion Groups, and the Exhibition. Please present your MSMS or other State Medical Association, AMA, or CMA Membership Card to expedite registration.

- **GUESTS**—Members of any state medical association, AMA, or CMA members from any province of Canada, and physicians of the Army, Navy, and U. S. Public Health Service are invited to attend as guests. No registration fee. Please present credentials at the registration desk.

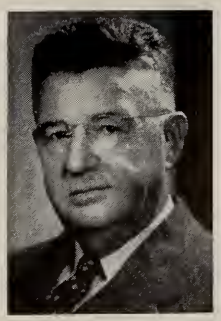
 Bona fide doctors of medicine who are associate or probationary members of Michigan county medical societies or who are serving as residents or interns, if vouched for by the president or secretary of the county medical society in whose jurisdiction they are located, will be registered as guests with no registration fee. Please present credentials at the registration desk.

- **MICHIGAN DOCTORS OF MEDICINE** in practice but who are not members of MSMS, if listed in the American Medical Association Directory, may register as guests upon payment of $25.00. This amount will be credited to them toward dues in the Michigan State Medical Society for 1961 *only*, provided they subsequently are voted into membership by the county medical society in whose jurisdiction they practice.

- **TELEPHONE SERVICE**—Local and long distance telephone service will be available in the Sheraton-Cadillac Hotel, fourth floor. In case of emergency, physicians will be paged from the meetings by an announcement on the screen. Call the Sheraton-Cadillac Hotel, Detroit, WOodward 1-8000, and ask for the Michigan Clinical Institute extensions on the fourth floor.

COLOR TV PROGRAM

beamed to the Grand Ballroom, Sheraton-Cadillac Hotel, through the cooperation of the staff of the Detroit Memorial Hospital and the Smith, Kline and French Laboratories of Philadelphia.
Wednesday-Thursday-Friday, March 8-9-10, from 10:30 a.m. to 1:00 p.m. (see pages 91, 95, 99 for complete program).



MILTON A. DARLING, M.D.

• **MILTON A. DARLING, M.D.,** Detroit, is General Chairman of Arrangements for the 1961 Michigan Clinical Institute.



JOHN W. SIGLER, M.D.

• **JOHN W. SIGLER, M.D.,** Detroit, is Chairman of the Program Committee for the 1961 Michigan Clinical Institute.



DONALD H. KAUMP, M.D.

• **DONALD H. KAUMP, M.D.,** Detroit, is Chairman of the Committee on Color TV Program for the 1961 Michigan Clinical Institute.

• **CHECKROOM** is available in the Sheraton-Cadillac Hotel, fourth floor, next to the Grand Ballroom.

• **GUEST SPEAKERS** are very respectfully requested not to change time of their lecture with another speaker without the approval of the Committee on Program. This request is made in order to avoid confusion as well as disappointment on the part of members of the audience.

• **PAPERS WILL BEGIN AND END ON TIME—** Nothing makes a scientific meeting more attractive than by-the-clock promptness and regularity; therefore, all meetings and symposia will open on time, all speakers will be required to begin their talks exactly on time and to close exactly on time, in accordance with the schedule in the program. All who attend the Institute are respectfully requested to assist in attaining this end by noting the schedule carefully and by being in attendance accordingly, in order not to miss that portion of the program of greatest interest.

• **TECHNICAL AND SCIENTIFIC EXHIBITS—** Seventy-five interesting and instructive displays will open on Wednesday-Thursday-Friday, March 8-9-10, at 9:30 a.m. The exhibits will close at 5:00 p.m. except on Friday when the show closes at 1:30 p.m. Frequent intermissions to view the exhibits have been arranged daily before, during, and after the assemblies.

• **THERE IS SOMETHING** of interest or education in the large exhibit of technical and scientific displays. **SAVE AN ORDER FOR THE EXHIBITOR AT THE MICHIGAN CLINICAL INSTITUTE.**

• **POSTGRADUATE CREDITS** are given to every MSMS member who attends the Michigan Clinical Institute. Notify John M. Sheldon, M.D., Chairman, Department of Postgraduate Medicine, University of Michigan Medical School, Ann Arbor.

• **PARKING**—Do not park on Detroit's streets. Inside parking at a convenient distance from the Sheraton-Cadillac Hotel is available at the DAC Garage, 1754 Randolph, the Grand Circus Garage, 1776 Randolph, and the Book Tower Garage, 333 State.

• **NEWS COMMITTEE** for the 1961 Michigan Clinical Institute: C. L. Weston, M.D., Owosso, Chairman, J. J. Coury, Jr., M.D., Port Huron, A. B. Gwinn, M.D., Hastings, D. H. Kaump, M.D., Detroit, C. A. Payne, M.D., Grand Rapids, and M. R. Weed, M.D., Detroit.

• **INFORMATION OF PRACTICAL VALUE IN DAILY PRACTICE** will be found at the Michigan Clinical Institute. All subjects on the Institute Program are applicable to clinical medicine. They stress diagnosis and treatment, usable in everyday practice.

MUCH THAT IS NEW AND INTERESTING WILL BE FOUND IN THE MCI EXHIBIT.

THE "BLOCK SYSTEM"
at the
1961 MICHIGAN CLINICAL INSTITUTE

WEDNESDAY, MARCH 8

General Practice Day

A.M.—Surgery
P.M.—Trauma

THURSDAY, MARCH 9

A.M.—Heart and Rheumatic Fever
P.M.—Internal Medicine

FRIDAY, MARCH 10

A.M.—Obstetrics-Gynecology

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D. Bruce Wiley, M.D., Utica

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HOTEL RESERVATIONS
MICHIGAN CLINICAL INSTITUTE

Detroit, March 8-9-10, 1961

The reservation blank below is for your convenience in making your hotel reservation in Detroit. Please send your application to B. Van De Keere, Sales Office, Sheraton-Cadillac Hotel, Detroit 31. Mailing your application NOW will be of material assistance in securing the type of hotel accommodations you desire.

As very few singles are available, registrants are requested to cooperate with the Committee on Hotels by sharing a room with another registrant, when convenient.

Committee on Hotels
Michigan Clinical Institute
c/o Sheraton-Cadillac Hotel
Detroit 31, Michigan
Attention: B. Van De Keere

Please make hotel reservation(s) as indicated below:

.....Single Room(s) Double Room(s) for

.....persons Twin-bedded Room(s) for.....

.....persons

Arriving March..... hour..... A.M..... P.M.....

Leaving March..... hour..... A.M..... P.M.....

Hotel of first choice:

Second choice:

Names and addresses of all applicants including person making reservations:

.....
name

.....
address

.....
city zone state

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name

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address

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city zone state

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name

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address

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city zone state

Signed:

Address:

City:

Date:

.....

Michigan Clinical Institute, 1961

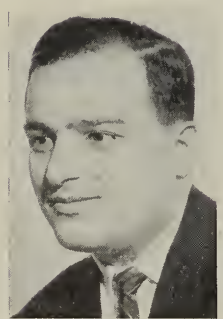
MCI SPEAKERS



George S. Fisher, M.D.



Michael J. Brennan, M.D.



Elmer F. Wahby, M.D.

Program

WEDNESDAY

March 8, 1961

7:45 a.m. to 5:00 p.m.—REGISTRATION—Fourth Floor

8:00 a.m. to 9:00 a.m.—THREE DISCUSSION GROUPS—Rooms on the Fifth Floor

9:00 a.m. to 5:00 p.m.—ASSEMBLY PROGRAM—Grand Ballroom

9:30 a.m. to 5:00 p.m.—EXHIBITION—Fourth Floor

10:30 a.m. to 1:00 p.m.—COLOR TV—Grand Ballroom

DISCUSSION GROUPS on

I "CHEMOTHERAPY IN MALIGNANT DISEASE"

8:00-9:00 a.m.—Sheraton Room (Fifth Floor)

Leader: George S. Fisher, M.D., Detroit
Attending Physician and Chairman, Department of Medicine; Chairman, Section of Hematology, The Grace Hospital; Consultant in Internal Medicine, Herman Kiefer Hospital; Instructor in Internal Medicine, Wayne State University College of Medicine; and Attending Physician, St. John Hospital

Panelists:
Michael J. Brennan, M.D., Detroit
Henry Ford Hospital, Detroit

Alvin Watne, M.D., Buffalo, New York
Associate Chief Cancer Research Surgeon, Roswell Park Memorial Institute

II "X-RAY DIAGNOSIS IN SURGICAL PRACTICE"

8:00-9:00 a.m.—East Room (Fifth Floor)

Leader: Steven J. Figiel, M.D., Detroit

Panelists:
Fred J. Hodges, M.D., Ann Arbor
Professor and Chairman, Department of Radiology, University of Michigan

Elmer F. Wahby, M.D., Grand Rapids
Chief, Department of Radiology, Butterworth Hospital

III "UNUSUAL FRACTURES"

8:00-9:00 a.m.—West Room

Leader: Herbert D. Pedersen, M.D., Dearborn

Panelists:
Robert W. Bailey, M.D., Ann Arbor

J. Otto Lottes, M.D., St. Louis, Missouri
Assistant Professor, Clinical Orthopedic Surgery, Washington University School of Medicine; President, Medical Staff, St. Anthony's Hospital; Chief Orthopedic Service, St. Anthony's Hospital

9:00 End of Discussion Groups

FIRST ASSEMBLY

Grand Ballroom

Chairman: Robert E. L. Berry, M.D., Ann Arbor
Secretary: Joseph A. Witter, M.D., Highland Park

GENERAL PRACTICE DAY

SURGERY

9:00 A.M.
"CURRENT CONCEPTS REGARDING SPREAD OF TUMOR CELLS"
Alvin L. Watne, M.D., Buffalo, New York
Associate Chief Cancer Research Surgeon, Roswell Park Memorial Institute

9:20 A.M.
"VALUE OF THE SCOUT FILM IN DIAGNOSIS OF THE ACUTE ABDOMEN"
Fred J. Hodges, M.D., Ann Arbor
Professor and Chairman, Department of Radiology, University of Michigan

9:40 A.M.
"CHRONIC ARTERIAL OCCLUSIVE DISEASE"
Herbert J. Robb, M.D., Detroit
Assistant Professor of Surgery, Wayne State University College of Medicine

10:00 A.M.

End of First Assembly
10:00 A.M.

INTERMISSION TO VIEW EXHIBITS
10:30 A.M.

COLOR TELEVISION PROGRAM—beamed to the Grand Ballroom, Sheraton-Cadillac Hotel, through the cooperation of the staff of Detroit Memorial Hospital and Smith, Kline and French Laboratories of Philadelphia.

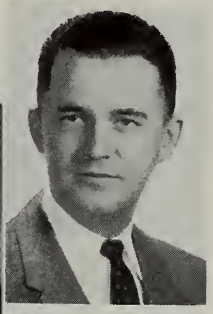
10:30 A.M.-11:00 A.M.
Panel on "ACNE PLANING"
Moderator:
Wm. G. McEvitt, M.D., Detroit
Operator:
Edward J. Hill, Jr., M.D., Detroit
Chief, Plastic Surgery, Mt. Carmel Mercy Hospital; Staff, Wm. Beaumont and Harper Hospitals; Instructor in Surgery, Wayne State University College of Medicine; Consultant in Plastic Surgery, Wayne State University College of Medicine

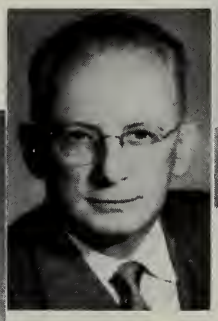
11:05 A.M.-1:00 P.M.
Panel on "ARTHRITIS, SELECTION OF PATIENTS FOR MEDICAL AND SURGICAL CARE"
Moderator:
James J. Lightbody, M.D., Detroit
Medical Director, Michigan Chapter, Arthritis and Rheumatism Foundation; Speaker, House of Delegates of the Michigan State Medical Society

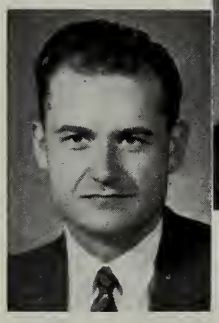
Panelists:
"Diagnosis of Arthritis and Collagen Disease"
Ivan F. Duff, M.D., Ann Arbor
Wm. M. Mikkelsen, M.D., Ann Arbor
Wm. D. Robinson, M.D., Ann Arbor

"Treatment of Bursitis"
James J. Horvath, M.D., Detroit
H. Ross Hume, M.D., Detroit

MCI SPEAKERS


Alvin Watne, M.D.


Fred J. Hodges, M.D.

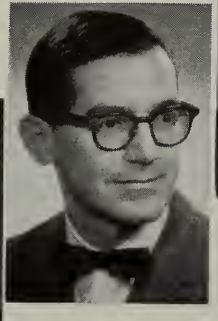

Herbert J. Robb, M.D.


Wm. G. McEvitt, M.D.


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James J. Lightbody, M.D.


Ivan F. Duff, M.D.


Wm. M. Mikkelsen, M.D.


Noyes L. Avery, Jr., M.D.

MCI SPEAKERS



DWIGHT C. ENSIGN, M.D.



E. N. ROTTENBERG, M.D.



MAX K. NEWMAN, M.D.



JOSEPH N. SCHAFFER, M.D.



HAROLD E. KLEINERT, M.D.



NICHOLAS S. GIMBLE, M.D.



CHESTER S. KEEFER, M.D.



RAYMOND W. WAGGONER, M.D.

"Use of Steroids and Drugs in Rheumatoid Arthritis and Gout"
NOYES L. AVERY, JR., M.D., Grand Rapids
DWIGHT C. ENSIGN, M.D., Franklin
Physician-in-Charge, Division of Arthritis, Henry Ford Hospital
MADELINE K. KEECH, M.D., Detroit
E. NEWTON ROTTENBERG, M.D., Detroit
Clinical Instructor in Medicine, Wayne State University College of Medicine; Chief, Arthritis Subsection, Sinai Hospital

"Knee Surgery in Arthritis"
BENJAMIN W. DROMPP, M.D., Detroit
L. CARL SULTZMAN, M.D., Detroit

"Physical Medicine and Rehabilitation in Arthritis"
MAX K. NEWMAN, M.D., Detroit
Director of Physical Medicine and Rehabilitation, Detroit Memorial Hospital
JOSEPH N. SCHAFFER, M.D., Detroit

1:00 P.M.

End of color television program

Luncheon

SECOND ASSEMBLY

Grand Ballroom

Chairman: HOMER M. SMATHERS, M.D., Detroit
Secretary: HOWARD C. REES, M.D., Detroit

GENERAL PRACTICE DAY
TRAUMA

2:00 P.M.
"THE TREATMENT OF TRAUMA IN CHILDREN"
JOHN L. KEELEY, SR., M.D., Chicago, Illinois

2:20 P.M.
"THE TREATMENT OF FRACTURED TIBIA"
J. OTTO LOTTES, M.D., St. Louis, Missouri
Assistant Professor, Clinical Orthopedic Surgeon, Washington University School of Medicine; President, Medical Staff, St. Anthony's Hospital; Chief Orthopedic Service, St. Anthony's Hospital

2:40 P.M.
"TRAUMA OF THE INJURED HAND"
HAROLD E. KLEINERT, M.D., Louisville, Kentucky
Assistant Professor of Surgery, University of Louisville School of Medicine

3:00 P.M.
INTERMISSION TO VIEW EXHIBITS

4:00 P.M.
Panel on "TREATMENT OF THE MULTIPLE INJURED PATIENT"
Moderator:
NICHOLAS S. GIMBLE, M.D., Detroit
Associate Professor of Surgery, Wayne State University College of Medicine
Panelists:
JOHN L. KEELEY, SR., M.D., Chicago, Illinois
HAROLD E. KLEINERT, M.D., Louisville, Kentucky
Assistant Professor of Surgery, University of Louisville School of Medicine
J. OTTO LOTTES, M.D., St. Louis, Missouri
Assistant Professor, Clinical Orthopedic Surgeon, Washington University School of Medicine; President, Medical Staff, St. Anthony's Hospital; Chief Orthopedic Service, St. Anthony's Hospital

4:40 P.M.
PHARMACEUTICAL LECTURE
"ANTIBIOTICS—THEIR USE AND MISUSE"
CHESTER S. KEEFER, M.D., Boston, Massachusetts
Wade Professor of Medicine, Boston University School of Medicine; Director, Boston University—Massachusetts Memorial Hospitals Medical Center; President, American College of Physicians

5:00 P.M.
End of Second Assembly

WEDNESDAY EVENING

March 8, 1961

Grand Ballroom
8:00 P.M.

Symposium on "THE USE AND ABUSE OF HYPNOSIS"

Moderator:

RAYMOND W. WAGGONER, M.D., Ann Arbor
Director, The Neuropsychiatric Institute, University Hospital

Panelists:

"Research in Hypnosis" (Accompanied by film strips)

MARTIN T. ORNE, M.D., Boston, Massachusetts
Senior Research Psychiatrist, Massachusetts Mental Health Center; Instructor in Psychiatry, Harvard Medical School; Director of the Studies in Hypnosis Project of Harvard Medical School

"The Use and Value of Hypnosis" (Illustrated by slides)

LOUIS J. WEST, M.D., Oklahoma City, Oklahoma
Professor of Psychiatry and Head of the Department of Psychiatry, Neurology, and Behavioral Sciences, The University of Oklahoma Medical Center

"Pitfalls of Hypnosis"

HAROLD ROSEN, M.D., Baltimore, Maryland
Associate Professor of Psychiatry, Johns Hopkins University. Chairman of the Committee on Hypnosis, Council on Mental Health of A.M.A. Author of text-book, "Hypnotherapy in Clinical Psychiatry."

Questions and Answers

* * * * *

Sandoz Pharmaceuticals, Division of Sandoz Chemical Works, Inc., Hanover, New Jersey, is co-sponsoring this program and will be host at a reception following the meeting during which informal discussion of the material presented will take place.

THURSDAY

March 9, 1961

7:45 a.m. to 5:00 p.m.—**REGISTRATION**—Fourth Floor
8:00 a.m. to 9:00 a.m.—**THREE DISCUSSION GROUPS**—Rooms on the Fifth Floor
9:00 a.m. to 5:00 p.m.—**ASSEMBLY PROGRAM**—Grand Ballroom
9:30 a.m. to 5:00 p.m.—**EXHIBITION**—Fourth Floor
10:30 a.m. to 1:00 p.m.—**COLOR TV**—Grand Ballroom

DISCUSSION GROUPS on
I "REPOSITORY ANTIGENS: PREPARATION, DEMONSTRATION, AND ADMINISTRATION"

8:00–9:00 a.m.—East Room

Leader:

FRED M. DAVENPORT, M.D., Ann Arbor
Professor of Epidemiology, School of Public Health; Professor of Internal Medicine, School of Medicine, University of Michigan

Panelists:

PETER P. BARLOW, M.D., Ann Arbor
Instructor in Internal Medicine, Allergy, and Postgraduate Medicine, University of Michigan Medical Center

SIDNEY FRIEDLAENDER, M.D., Detroit
Assistant Clinical Professor of Medicine and Associate in Microbiology, Wayne State University College of Medicine; Attending Staffs, Department of Medicine, Receiving, Sinai, and Grace Hospitals; Michigan Regional Consultant in Allergic Disease, Veterans Administration

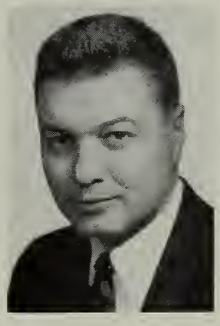
MCI SPEAKERS



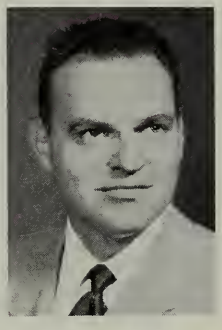
MARTIN T. ORNE, M.D.



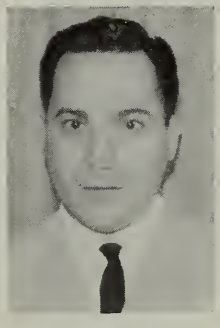
HAROLD ROSEN, M.D.



LOUIS J. WEST, M.D.



FRED M. DAVENFORT, M.D.

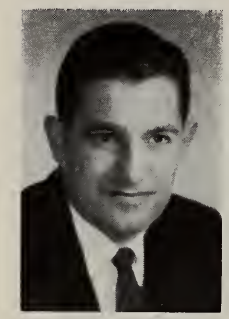


PETER P. BARLOW, M.D.



SIDNEY FRIEDLAENDER, M.D.

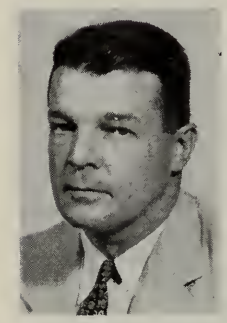
MCI SPEAKERS



FREEMAN M. WILNER, M.D.



CHRIS J. D. ZARAFONETIS, M.D.



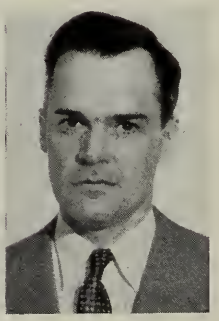
PRESCOTT JORDAN, JR., M.D.



CHARLES P. BAILEY, M.D.



FRANKLIN D. JOHNSTON, M.D.



RICHARD A. RASMUSSEN, M.D.

II "ANEMIA"

8:00–9:00 a.m.—West Room

Leader:
RAYMOND W. MONTO, M.D., Detroit
Physician-in-charge, Division of Hemotology, Henry Ford Hospital

Panelists:
FREEMAN M. WILNER, M.D., Detroit
Clinical Instructor, Department of Internal Medicine, Wayne State University College of Medicine; Consultant in Hematology, Herman Kiefer Hospital and Bon Secour Hospital; Attending Hematologist at Providence, Woman's, Detroit Memorial, Holy Cross, St. Mary's, Livonia, and Highland Park General Hospitals.

CHRIS J. D. ZARAFONETIS, M.D., Philadelphia, Pennsylvania
Professor of Internal Medicine; Director, The Simpson Memorial Institute

III "SELECTION OF PATIENTS FOR CARDIAC SURGERY"

8:00–9:00 a.m.—Sheraton Room

Leader:
PRESCOTT JORDAN, JR., M.D., Detroit
Associate Professor of Surgery, Wayne State University College of Medicine; Director, Cardiovascular Surgery Section, Children's Hospital

Panelists:
CHARLES P. BAILEY, M.D., New York, New York
Chairman and Professor, Department of Surgery, New York Medical College

FRANKLIN D. JOHNSTON, M.D., Ann Arbor
Professor of Internal Medicine, University of Michigan Medical School

RICHARD R. RASMUSSEN, M.D., Grand Rapids
Thoracic Surgeon; Member Cardiac Group, Blodgett Memorial Hospital

9:00 A.M.
End of Discussion Groups

THIRD ASSEMBLY

Grand Ballroom

Chairman: JOHN D. LITTIG, M.D., Kalamazoo
Secretary: SIDNEY E. CHAPIN, M.D., Dearborn

9:00 A.M.
"CLINICAL USE OF THE ELECTROCARDIOGRAM"
FRANKLIN D. JOHNSTON, M.D., Ann Arbor
Professor of Internal Medicine, University of Michigan Medical School

9:20 A.M.
"DIGITALIS"
RICHARD J. BING, M.D., Detroit
McGregor Professor of Medicine; Chairman, Department of Medicine; Wayne State University College of Medicine

9:40 A.M.
"THE VALUE OF DIAGNOSTIC WORK-UP IN RESPECT TO CARDIAC SURGERY"
RICHARD A. RASMUSSEN, M.D., Grand Rapids
Thoracic Surgeon; Member Cardiac Group, Blodgett Memorial Hospital

10:00 A.M.
End of Third Assembly

10:00 A.M.
INTERMISSION TO VIEW EXHIBITS

10:30 A.M.

COLOR TELEVISION PROGRAM—beamed to the Grand Ballroom, Sheraton-Cadillac Hotel, through the cooperation of the staff of Detroit Memorial Hospital and Smith, Kline and French Laboratories of Philadelphia.

10:30-11:25 A.M.

Panel on "THE DISABLED HAND"

Moderator:

JOSEPH L. POSCH, M.D., Detroit

Operator:

ROBERT D. LARSEN, M.D., Detroit

Panelists:

EDWARD M. FUGATE, M.D., Muskegon
Diplomate of the American Board of Surgery; Fellow American College of Surgeons, Assistant Chief, Disaster Planning Committee for Muskegon County; and Member, Michigan Regional Committee on Trauma, American College of Surgeons

JOHN M. PENDY, M.D., Detroit

ALBERT VAN'T HOF, M.D., Grand Rapids
Consultant in Trauma and Surgery of the Hand, St. Mary's Hospital and Blodgett Memorial Hospital; Chief Out-Patient and Emergency Department, St. Mary's Hospital; Medical Director American Red Cross Kent County Chapter

11:30 A.M.-12:10 P.M.

Panel on "EXAMINATION FOR PERIPHERAL VASCULAR DISEASE"

Moderator:

EUGENE A. OSIUS, M.D., Detroit
Chief of Staff and Chief, Department of Surgery, Harper Hospital; Clinical Associate Professor of Surgery, Wayne State University College of Medicine; Consultant, Herman Kiefer, Oakwood, Children's Hospitals of Michigan

Panelists:

ROBERT E. L. BERRY, M.D., Ann Arbor
ROGER F. SMITH, M.D., Detroit
Associate in Surgery, Department of Surgery, Henry Ford Hospital

MCI SPEAKERS



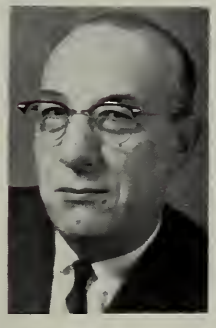
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EUGENE A. OSIUS, M.D.

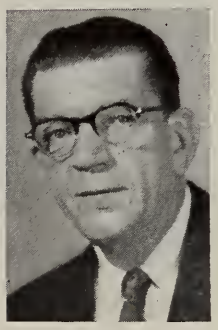


ROBERT E. L. BERRY, M.D.



ROGER F. SMITH, M.D.

MCI SPEAKERS



GAYLORD S. BATES, M.D.



DARRELL A. CAMPBELL, M.D.



JAMES W. LOGIE, M.D.



J. EDWARD MANNING, M.D.



JOHN H. TALBOTT, M.D.

12:15-1:00 P.M.

"MANAGEMENT OF THE RECURRENT HERNIA"

Moderator:

GAYLORD S. BATES, M.D., Dearborn
Associate Clinical Professor of Surgery, Wayne State University College of Medicine; Senior Surgeon, Oakwood Hospital, Dearborn

Operator:

GORDON K. GLASGOW, M.D., Detroit
Attending Surgeon, Detroit Memorial Hospital; Consulting Surgeon, Cottage and East Side General Hospitals

Panelists:

DARRELL A. CAMPBELL, M.D., Ann Arbor
Immediate Past President, Washtenaw County Medical Society; Secretary-Treasurer, Michigan Chapter, American College of Surgeons; Attending Surgeon St. Joseph Mercy Hospital

JAMES W. LOGIE, M.D., Grand Rapids
Consultant and Vice Chief-of-Staff, Blodgett Memorial Hospital and Consultant in Surgery, St. Mary's Hospital

J. EDWARD MANNING, M.D., Saginaw
Member of Senior Staff, Saginaw General Hospital; Chief of the Department of Surgery, Saginaw General Hospital; Diplomat of the American Board of General Surgery

1:00 P.M.

End of color television program

Luncheon

FOURTH ASSEMBLY

Grand Ballroom

Chairman: JOHN M. SHELDON, M.D., Ann Arbor
Secretary: BERT M. BULLINGTON, M.D., Saginaw

INTERNAL MEDICINE

2:00 P.M.

"THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION"

JOHN H. TALBOTT, M.D., Chicago, Illinois
Director of Scientific Publications, American Medical Association

2:20 P.M.

"PERCUTANEOUS NEEDLE BIOPSY OF THE KIDNEY"

THOMAS M. BATCHELOR, M.D., Detroit
Clinical Instructor in Medicine, Wayne State University College of Medicine

2:40 P.M.

MICHIGAN CANCER COORDINATING COMMITTEE LECTURE

"CHEMOTHERAPY VS OBLATIVE PROCEDURES IN DISSEMINATED BREAST CANCER"

ANTHONY R. CURRERI, M.D., Madison, Wisconsin
Professor of Surgery and Director, Cancer Research Hospital

3:00 P.M.
INTERMISSION TO VIEW EXHIBITS

4:00 P.M.
"STINGING INSECTS—A THREAT TO LIFE"
JOSEPH H. SHAFFER, M.D., Detroit
Chief, Allergy Division, Henry Ford Hospital; Fellow, American Academy of Allergy, American College of Allergy, International Association of Allergology and American College of Physicians

4:20 P.M.
"CLINICAL ASPECTS OF DISORDERS ASSOCIATED WITH HEREDITARY ERYTHROCYTE DEFECTS"
CHRIS J. D. ZARAFONETIS, M.D., Philadelphia, Pennsylvania
Professor of Internal Medicine; Director, The Simpson Memorial Institute

4:40 P.M.
MICHIGAN FOUNDATION FOR MEDICAL AND HEALTH EDUCATION LECTURE
"THE SURGICAL TREATMENT OF MITRAL STENOSIS AND INSUFFICIENCY"
CHARLES P. BAILEY, M.D., New York, New York
Chairman and Professor, Department of Surgery, New York Medical College

5:15 P.M.
End of Fourth Assembly

THURSDAY EVENING
March 9, 1961

Grand Ballroom

8:00 P.M.
Panel Discussion on "THE CARE OF OLDER PEOPLE IN NURSING HOMES"

FRIDAY
March 10, 1961

7:45 a.m. to 5:00 p.m.—REGISTRATION—Fourth Floor
8:00 a.m. to 9:00 a.m.—TWO DISCUSSION GROUPS—Rooms on the Fifth Floor
9:00 a.m. to 10:00 a.m.—ASSEMBLY PROGRAM—Grand Ballroom
9:30 a.m. to 1:00 p.m.—EXHIBITION—Fourth Floor
10:30 a.m. to 1:00 p.m.—COLOR TV—Grand Ballroom

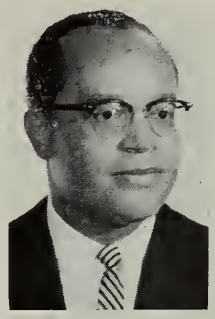
DISCUSSION GROUPS on
I "NEWER DRUGS IN THE TREATMENT OF PREGNANCY TOXEMIA"
8:00–9:00 a.m.—East Room

Leader:
CHARLES S. STEVENSON, M.D., Detroit

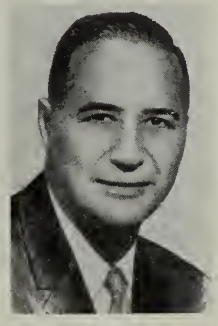
Panelists:
DAVID N. DANFORTH, M.D., Evanston, Illinois
Professor of Obstetrics and Gynecology Northwestern University Medical School; Chief, Department of Obstetrics-Gynecology, Evanston Hospital

ARTHUR G. SESKI, M.D., Detroit
Chairman, Department of Obstetrics, Woman's Hospital; Instructor, Wayne State University College of Medicine; Diplomat American Board of Obstetricians and Gynecologists; Fellow of the American College of Surgeons and of the American College of Obstetricians and Gynecologists; Charter Member of the Correspondence Society of Obstetricians and Gynecologists

MCI SPEAKERS



THOMAS M. BATCHELOR, M.D.



ANTHONY R. CURRERI, M.D.



JOSEPH H. SHAFFER, M.D.



CHARLES S. STEVENSON, M.D.



DAVID N. DANFORTH, M.D.

MCI SPEAKERS



FRANCIS A. JONES, JR., M.D.



CHARLES A. BEHNEY, M.D.



LAUREL S. ENO, M.D.



EDWARD C. MANN, M.D.



TOMMY N. EVANS, M.D.



GLENN I. HILLER, M.D.



J. EDWARD BERK, M.D.

II "SERIOUS COMPLICATIONS OF PREGNANCY"

8:00–9:00 a.m.—West Room

Leader:

FRANCIS A. JONES, JR., M.D., Lansing
Diplomat of American Board of Obstetrics and Gynecology

Panelists:

CHARLES A. BEHNEY, M.D., Lansing
Maternal Health Consultant, Division of Maternal and Child Health, Michigan Department of Health

LAUREL S. ENO, M.D., Detroit
Surgeon, Department of Obstetrics and Gynecology, Harper Hospital; Attending Physician, St. John and Jennings Memorial Hospitals; Chairman of the Maternal Welfare Committee of the Wayne County Medical Society; Member of the Perinatal Death Committee of the Michigan Society of Obstetricians and Gynecologists

EDWARD C. MANN, M.D., New York, New York
Assistant Professor of Obstetrics and Gynecology, Cornell Medical College

9:00 A.M.
End of Discussion Groups

FIFTH ASSEMBLY

Grand Ballroom
Chairman: JAMES H. BEATON, M.D., Grand Rapids

OBSTETRICS-GYNECOLOGY

9:00 A.M.

"THE PROBLEM OF FEMALE FRIGIDITY"

EDWARD C. MANN, M.D., New York, New York
Assistant Professor of Obstetrics and Gynecology, Cornell Medical College

9:20 A.M.
"MANAGEMENT OF ABORTION"

DAVID N. DANFORTH, M.D., Evanston, Illinois
Professor of Obstetrics and Gynecology; Northwestern University Medical School; Chief, Department of Obstetrics and Gynecology, Evanston Hospital

9:40 A.M.
"INFERTILITY DUE TO ANOVULATORY OVARIAN FUNCTION"

TOMMY N. EVANS, M.D., Ann Arbor
Professor of Obstetrics and Gynecology, University of Michigan

10:00 A.M.

End of Fifth Assembly

10:00 A.M.
INTERMISSION TO VIEW EXHIBITS

10:30 A.M.

COLOR TELEVISION PROGRAM—beamed to the Grand Ballroom, Sheraton-Cadillac Hotel, through the cooperation of the staff of Detroit Memorial Hospital and Smith, Kline and French Laboratories of Philadelphia.

10:30-11:30 A.M.

Panel on "JAUNDICE AND DIAGNOSIS IN LIVER DISEASE"

Moderator:

GLENN I. HILLER, M.D., Detroit
Attending Physician, Department of Internal Medicine, Providence Hospital; Clinical Instructor in Medicine, Wayne State University College of Medicine; Member of American Federation of Clinical Research; Diplomat of American Board of Internal Medicine; Member of A.A.A.S.; and Member of International Society of Internal Medicine

Panelists:

J. EDWARD BERK, M.D., Detroit
Director, Department of Medicine, Sinai Hospital of Detroit and Associate Professor of Clinical Medicine, Wayne State University College of Medicine

ELSTON R. HUFFMAN, M.D., Marquette
Private Practice of Internal Medicine; Staff of St. Luke's and St. Mary's Hospitals

C. ALLEN PAYNE, M.D., Grand Rapids
Director of Laboratories, Blodgett Memorial Hospital

SHERWOOD B. WINSLOW, M.D., Battle Creek
Chief of Surgery, Leila I. Post Montgomery Hospital; Surgery Staff, Community Hospital, Battle Creek Health Center and Kimball Sanatorium

11:35 A.M.-12:15 P.M.

Panel on "RESPIRATORY FUNCTION AND INHALATION THERAPY"

Moderator:

E. OSBORNE COATES, JR., M.D., Detroit
Physician-in-charge, Pulmonary Division, Henry Ford Hospital

Panelists:

ABRAHAM BECKER, M.D., Detroit
Clinical Assistant Professor of Medicine, Wayne State University College of Medicine

HOWARD H. FEIGELSON, M.D., Detroit
Director, Department of Radiology, Sinai Hospital; Instructor, Department of Radiology, Wayne State University College of Medicine

BENJAMIN M. LEWIS, M.D., Detroit
Associate Professor of Medicine, Wayne State University College of Medicine

MCI SPEAKERS



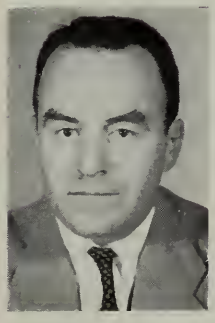
ELSTON R. HUFFMAN, M.D.



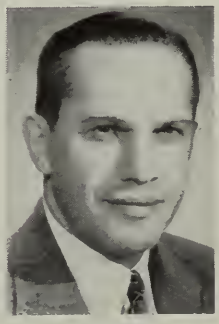
C. ALLEN PAYNE, M.D.



SHERWOOD B. WINSLOW, M.D.



E. OSBORNE COATES, JR., M.D.



ABRAHAM BECKER, M.D.

MCI SPEAKERS



GLEN E. HAUSE, M.D.



S. SPRIGG JACOB, M.D.



RUBEN MEYER, M.D.

12:20 P.M.-1:00 P.M.
Panel on "CARE OF THE NEWBORN CHILD"

Moderator:

GLEN E. HAUSE, M.D., Detroit
Fellow of the American Academy of Pediatrics; Chairman, Department of Pediatrics, Mt. Carmel Mercy Hospital

Panelists:

"EXAMINATION AND CARE OF THE PREMATURE NEWBORN"

EDWARD P. GUNDERSON, M.D., Manistee
Fellow, American Academy of Pediatrics

"RH PROBLEM OF THE NEWBORN"

S. SPRIGG JACOB, M.D., East Lansing
President, Western Michigan Pediatric Society; Chief of Pediatric Department, Edward W. Sparrow Hospital

"RESPIRATORY PROBLEMS IN THE NEWBORN WITH EMPHASIS ON THE APPROVED METHODS OF RESUSCITATION"

RUBEN MEYER, M.D., Detroit
Associate Professor of Pediatrics, Wayne State University College of Medicine

Demonstrations

SHIRLEY M. AUSTIN, M.D., Detroit
Assistant Professor of Anesthesiology, Wayne State University College of Medicine; Chief Anesthetist, Children's Hospital

1:00 P.M.
End of color television program

1:00 P.M.
FINAL INTERMISSION TO VIEW EXHIBITS

1:30 P.M.
End of 1961 Michigan Clinical Institute

DISCUSSION GROUPS

Topics of interest and practical value to all members of the Michigan State Medical Society have been chosen. Qualified men have been selected as Moderators and Panelists. All Groups from 8:00 to 9:00 a.m. are scheduled as follows:

three on Wednesday, March 8
three on Thursday, March 9
two on Friday, March 10

See complete program on pages 90, 93, 97.

Members may submit in writing three weeks before the MCI, through Chairman of the Program Committee, John W. Sigler, M.D., questions concerning any phase of the subjects listed on the following official form. Moderators and Panelists will answer those questions which they feel are applicable to the subject under discussion, and will answer as many questions, including questions from the floor, as time permits.

Due to room capacities, each Discussion Group must be limited to thirty registrants—taken on a first-come, first-served basis. Admission tickets will be supplied to those who apply to the Michigan Clinical Institute, Box 539, Lansing 3.

Michigan Clinical Institute
Att: John W. Sigler, M.D., Chairman
Program Committee
c/o P.O. Box 539
Lansing 3, Michigan

Enroll me in the following Discussion Group:

WEDNESDAY, MARCH 8

☐ Chemotherapy in Malignant Disease

☐ X-ray Diagnosis in Surgical Practice

☐ Unusual Fractures

THURSDAY, MARCH 9

☐ Repository Antigens: Preparation, Demonstration, and Administration

☐ Anemia

☐ Selection of Patients for Cardiac Surgery

FRIDAY, MARCH 10

☐ Newer Drugs in the Treatment of Pregnancy Toxemia

☐ Serious Complications of Pregnancy

Technical Exhibits

(Listed by Name Alphabetically)

Abbott Laboratories — **Booth No. 43**
North Chicago, Ill.

Abbott Laboratories invite you to visit our exhibit. Our representatives will be happy to answer any questions you may have concerning our leading products and new developments.

A. S. Aloe Company — **Booth No. 60**
St. Louis, Mo.

20th Century Professional Furniture by Aloe will be displayed by the A. S. Aloe Company in Booth No. 60. This new line embodies many innovations and utilizes many of the materials which are the products of more recent scientific developments. A complete assortment of tables, cabinets and accessory items will be included.

American Cyanamid Company — **Booth No. 47**
Danbury, Conn.

American Cyanamid Company, Surgical Products Division, Danbury, Connecticut—A complete line of Surgilope SP sutures and the unique SP Service Program offer new standards of product quality and safety in handling sterile sutures. A complete line of Vim Hypodermic Needles and Syringes and other surgical specialties will also be on display.

Atlas Pharmaceutical Labs., Inc. — **Booth No. 25**
Detroit, Mich.

Ayerst Laboratories — **Booth No. 52**
Chicago, Ill.

"RIOPAN" is a new chemical entity that provides a true buffer-antacid for speedy and prolonged maintenance of the gastric pH level in the "safe" 3.5-5.5 range. "THIOSULFIL" FORTE provides effective therapy that can be given without interruption in urinary tract infections, especially in cases complicated by urinary stasis.

Barry Laboratories, Inc. — **Booth No. 15**
Detroit, Mich.

THREE IMPORTANT PRODUCTS YOU SHOULD KNOW ABOUT!

BARTHRO—The Enzyme approach to Arthritis—IMPORTANT!

MERPHENE—The stable germicide that will not injure mucous linings but will *KILL* antibiotic resistant staphylococcus aureus in less than 30 seconds or tetanus spores in less than 5 minutes.

ALLERGY TESTING THE EASY ACCURATE WAY

S. H. Camp & Company — **Booth No. 6**
Jackson, Mich.

On display are many new products and the latest developments in Camp Supports and Appliances designed to achieve better function when indicated in your practice. Members of the Camp staff are waiting to show and explain their value to you. Patients benefit from Camp's low prices, high quality and ease of procurement.

Coca-Cola Company — **Booths Nos. 63-64**
Atlanta 1, Ga.

Ice-cold Coca-Cola served through the courtesy and cooperation of the Detroit Coca-Cola Bottling Company and The Coca-Cola Company.

Desitin Chemical Co. — **Booth No. 13**
Providence, R. I.

DESITIN OINTMENT: Pioneer CLO ointment for treatment of: Burns, Ulcers, Diaper Rash, Abrasions, etc.

DESITIN POWDER: Saturated with CLO, Dainty, relieves Chafing, Sunburn, Diaper Rash, etc.

DESITIN HEMORRHOIDAL SUPPOSITORIES, and RECTAL OINTMENT: Relieve pain and itching, promote healing, give comfort in uncomplicated hemorrhoids, fissures. No anesthetics or styptics.

DESITIN BABY LOTION: Protective, antiseptic, emollient, contains no mineral oil, cleanses baby skin with tender care.

DESITIN ACNE CREAM: A non-staining, flesh-tinted "Medicream" for the treatment of Acne Vulgaris, skin blemishes, effective in removal of skin oiliness. Antiseptic.

DESITIN COSMETIC and NURSERY SOAP: Supermild, pleasantly scented, antiseptic and deodorant.

Doho Chemical Corporation — **Booth No. 49**
New York, N. Y.

DOHO CHEMICAL CORPORATION IS PLEASED TO EXHIBIT:

AURALGAN: Ear medication for relief of pain in Otitis Media; also removal of Cerumen.

RHINALGAN: Nasal decongestant free from systemic or circulatory effect. Safe for infants—aged.

OTOSMOSAN: Non-Toxic fungicide-bactericide (Gram negative-Gram positive) for suppurative and aural dermatomycotic ears.

LARYLGAN: Soothing throat spray and gargle for infectious and non-infectious sore throat involvements.

BIOTOSMOSAN HC: The solution to the "Problem Ear." Anti-microbial, Anti-inflammatory, De-inflammatory, Anti-allergic, Anti-pruritic.

Eaton Laboratories — **Booth No. 42**
Norwich, N. Y.

NEW FURADANTIN® (brand of nitrofurantoin) SODIUM FOR INTRAVENOUS USE—an alternative route of administration for Furadantin in patients unable to take oral medication.

FURADANTIN SODIUM for Intravenous Use fills a need for a parenteral form in the treatment of genitourinary infections, such as pyelonephritis, pyelitis, cystitis, prostatitis—and in selected systemic infections—even some which have failed to respond to other antibacterial therapy.

Edison Voicewriter Division — **Booth No. 51**
McGraw-Edison Company
West Orange, N. J.

Encyclopedia Americana **Booth No. 4**
Grand Rapids, Mich.

ENCYCLOPEDIA AMERICANA invites you to inspect their 1961 edition which leading educators find superior and prefer to any other reference work. No accredited school, college, university, or library is without it. The United States government has ordered more than a thousand sets for use in all major departments. Your visit to our booth will be most cordially welcomed and we have a souvenir for you without obligation.

Encyclopaedia Britannica **Booth No. 34**
Detroit, Mich.

Ferndale Surgical, Inc. **Booth No. 55**
Division of J. F. Hartz Company
Ferndale, Mich.

The latest in diagnostic, surgical instruments and equipment. Please ask for the new Ferndale General Catalogue, and our Therapeutic Index and price list.

C. A. Fisher & Sons **Booth No. 29**
"Zimmer" Distributor
Toledo, Ohio

Your ZIMMER distributor, C. A. Fisher & Sons extends a cordial invitation to visit their booth where the latest in Fracture Equipment and Appliances will be on display. Of special interest is the new HEMO VAC, the disposable pump and wound tubing for wound suction drainage.

E. Fougera & Company, Inc. **Booth No. 53**
Hicksville, N. Y.

The exhibit of E. Fougera Co., Inc., will feature both its established products and newer products of a specialty nature, of interest to physicians in many areas of medicine. Product information and clinical literature, together with office aids will be available, or will be forwarded to your office if you wish. All physicians are cordially invited to stop by.

Fuller Pharmaceutical Company **Booth No. 39**
Minneapolis, Minn.

THERAPADS—A unique new approach to daytime acne care will be shown for the first time. Of course, TUCKS and its new witch hazel analogue TRIAMEL Ointment and Cream are both available to renew old acquaintances and make new friends. Supplies of THERAPADS, TUCKS and TRIAMEL for personal use or clinical trial will be gladly sent you on request.

Geigy Chemical Corporation **Booth No. 44**
Yonkers, N. Y.

Geigy cordially invites Members and Guests of the Association to its display booths. The newest techniques relating to bowel hygiene in addition to more recent developments in therapy of cardiovascular, metabolic and psychiatric disorders may be discussed with physicians and representatives in attendance.

Hack Shoe Company **Booth No. 2**
Detroit, Mich.

We'll be there, by Hack!

G. A. Ingram Company **Booth Nos. 65-66**
Detroit, Mich.

A. Kuhlman & Company **Booth No. 30**
Detroit, Mich.

You are cordially invited to visit our booth and discuss with us our complete line of examining room furniture, diagnostic instruments, surgical instruments and physical therapy equipment.

Lederle Laboratories **Booth No. 28**
Pearl River, N. Y.

Your Lederle representative will be on hand to serve you. He can furnish information on any Lederle product and is prepared to bring to bear on any of your medical problems the knowledge of the worldwide Lederle research organization.

Eli Lilly & Company **Booth No. 61**
Indianapolis, Ind.

You are cordially invited to visit the Lilly exhibit located in space No. 61. The Lilly salespeople in attendance welcome your questions about Lilly products and recent therapeutic developments.

J. B. Lippincott Company **Booth No. 7**
Philadelphia, Pa.

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

Lloyd Brothers, Inc. **Booth No. 59**
Cincinnati, Ohio

Welcome to the Lloyd Brothers exhibit. Our professionally trained sales representatives will be pleased to greet you and discuss the merits of our products in your practice. Of particular interest will be a new booklet on erythropoietin, the trythropoietic hormone.

Maico Hearing Service **Booth No. 67**
Detroit, Mich.

The new Maico Hearing Aid weighing less than one-half ounce is so small that the entire unit consisting of transmitter, microphone, receiver, battery and ear mold is worn in the ear. A complete line of instruments to take care of cases from the borderline to the profoundly deaf.

Ninety per cent of all precision hearing test instruments used in America by ear physicians are Maico.

Marion Laboratories, Inc. **Booth No. 31**
Kansas City, Mo.

CAPRE' PRENATAL

"A trial in practice" study conducted over a nine-month period demonstrated Capré to be overwhelmingly well received by patients and physicians. Hemoglobin responses were excellent. Supplemental iron needs negligible. Side effects minimal. Care was given to the development of a therapeutically effective formula in a one-tablet-daily dosage level. Copies of study are available for your reference.

DUOTRATE

Cardiovascular problems requiring vasodilation can be effectively treated with less expense, less inconvenience and greater therapeutic effect. Duotrate PLATEAU CAPS provide a continuous method of drug release on a b.i.d. dosage—available in four dosage combinations. We invite you to visit our booth for information and reprints of current studies.

Marshall Erdman & Associates **Booth No. 35**
Madison, Wis.

ERDMAN MEDICAL BUILDINGS

Erdman Prefabricated Medical Buildings are the result of years of experience in the field of design, manufacturing and construction. No other company has had as extensive experience in this field. Over 300 doctors are now practicing in Erdman-built Medical Buildings in over 20 states.

Experienced Architects, Engineers and Construction Superintendents of the Erdman Company will design, manufacture and build your Medical Building from the land-planning stage until you open the door into your own office.

Contact Marshall Erdman & Associates, Inc., Madison, Wisconsin, before you build.

Mead Johnson & Company **Booth No. 70**
Evansville, Ind.

The Mead Johnson exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

Medco Products Company **Booth No. 48**
Tulsa, Okla.

Presenting the MEDCO-SONLATOR. Providing a new concept in therapy by combining muscle stimulation and ultra sound simultaneously through a SINGLE Three-Way Sound Applicator.

THE MEDCO-SONLATOR is a distinct advance in the effectiveness of physical therapy in your office or hospital. A few minutes spent in our booth should prove of value to your practice.

Medical Protective Company **Booth No. 32**
Fort Wayne, Ind.

As the No. 1 Malpractice Insurer, The Medical Protective Company offers unexcelled coverage. With exceptional proficiency in defense, so essential to the Doctor's protection today, its experience in successfully handling 81,000 claims and suits during sixty-two years of Professional Protection Exclusively is unparalleled in the professional liability field.

Merck Sharp & Dohme **Booth No. 21**
Division of Merck & Co., Inc.
West Point, Pa.

Wm. S. Merrell Company **Booth No. 50**
Cincinnati, Ohio

A summary of mounting clinical evidence attesting to the effectiveness of MER/29 in patients with hypercholesterolemia and related conditions will be presented by MERRELL. Update your knowledge of MER/29 by stopping briefly at the MERRELL display. Salesmen will summarize the extensive results of MER/29 therapy for you and answer questions you may have. Best wishes for a most enjoyable convention.

Meyer & Company **Booth No. 62**
St. Clair Shores, Mich.

ATHEMOL—Each tablet contains 200 mg. Magnesium 3-7 dimethyl-xanthine oleate, the magnesium double salt of dimethyl-xanthine and oleic acid.

Indications: Arteriosclerosis and its consequences: Arterial Hypertension, Cerebral Sclerosis, Atherosclerosis, coronary insufficiency, etc.

LEVAMINE—Antispasmodic—anticholinergic — sedative. Each Levamine tablet contains Butabarbital 15 mg. and 1-Hyoscyamine 0.15 mg. while each Levamine Duracap contains Butabarbital 45 mg. and 1-Hyoscyamine 0.45 mg.

Indications: Peptic ulcer, visceral spasm and in conditions where smooth, effective antispasmodic action is needed (diarrhea, tension states, pylorospasm, spastic colon, urinary tract spasm), coupled with mild sedation.

Michigan Medical Service **Booth No. 3**
Detroit, Mich.

You are cordially invited to visit our booth to obtain current information regarding Michigan Medical Service (Blue Shield). Our representatives will gladly visit with you and answer any questions you may have with regard to your Blue Shield Plan.

MSMS Life, Health & Accident Insurance Program **Booth No. 20**
Lansing, Mich.

You are cordially invited to stop at Booth No. 20 and discuss the MSMS Life, Health and Accident Insurance Program.

Representatives of the MSMS carriers will be present to answer questions concerning your MSMS group coverage.

Milex Products **Booth No. 33**
Oak Park, Mich.

Milex Company is pleased to exhibit our line of gynecic specialties as Milex folding pessaries, Trimo-San, Amino-Cerv, marital and menopause guides, infertility products, cancer detection unit and announcing a new type Diaphragm and a new product in fertility.

Ortho Pharmaceutical Corporation **Booth No. 36**
Raritan, N. J.

At Booth 36, ORTHO is presenting the new monilicidal vaginal cream, SPOROSTACIN. This emollient white cream contains the unique chemical, chlordantoin, which, because of its structure, has the unusual ability to penetrate the monilial membrane. Clinically proved, SPOROSTACIN Chlordantoin Cream is the treatment of choice in monilial vaginitis.

Parke, Davis & Company **Booth Nos. 40-41**
Detroit, Mich.

Medical service members of our staff will be in attendance at our booth to discuss important Parke-Davis specialties which will be on display.

Pet Milk Company **Booth No. 8**
St. Louis, Mo.

We shall be pleased to have you stop and discuss the variety of time-saving material available to busy physicians. Our representatives will be on hand to discuss the merits of "Pet" Evaporated Milk for infant feeding and "Pet" INSTANT Nonfat Dry Milk for special diets.

Pfizer Laboratories **Booth No. 24**
Brooklyn, N. Y.

The Pfizer Laboratories' display has been specifically arranged for your convenience and to give you the maximum in quick service and product information. To make your visit worthwhile, technically trained Medical Service Representatives will be on hand to discuss with you the latest developments in Pfizer research.

Randolph Surgical Supply Company **Booth Nos. 10-11**
Detroit, Mich.

RANDOLPH SURGICAL SUPPLY COMPANY will have their qualified personnel attending their booth, and have on display many new items of interest for the medical profession.

R. J. Reynolds Tobacco Company **Booth No. 23**
Winston-Salem, N. C.

Welcome to the R. J. Reynolds Tobacco Company Exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMEL, WINSTON Filter, Menthol Fresh SALEM, or CAVALIER King Size Cigarettes.

Roche Laboratories **Booth No. 14**
Nutley, N. J.

Librium—a therapeutic agent for superior, safer, faster control of nervousness, anxiety, tension and other common emotional disturbances without the dulling effect or depressant action of the tranquilizers.

Madribon—is a completely different, low-dosage sulfonamide of particular value in the treatment of bacterial infections especially respiratory infections.

Tigan—a specific antiemetic agent effective both prophylactically and therapeutically against most clinically significant types of nausea and vomiting.

Ross Laboratories, Inc. **Booth No. 37**
Columbus, Ohio

Ross Laboratories, who also manufactures Similac, features SIMILAC WITH IRON, a new prepared infant formula supplying 12 mg. of ferrous iron per quart of formula. SIMILAC WITH IRON is designed for use at the time exogenous iron is indicated in infancy to support the usual diet and to provide prophylaxis against iron deficiency during the period of greatest incidence, from 6 to 18 months of life. Some special indications for use are following placental or traumatic blood loss, for prematures and twins, for the pallid, irritable, anorectic infant with an unsatisfactory blood picture and following prolonged infection or diarrhea.

Rupp & Bowman Company **Booth No. 45**
Highland Park, Mich.

The Rupp & Bowman Company once again is honored to exhibit at your spring meeting. Stop in and visit our booth. We expect to have some new items of interest to you.

Sanborn Company **Booth No. 17**
Waltham, Mass.

New ELECTROCARDIOGRAPHS of advanced design and function, as well as latest models of other instruments for diagnostic use, will be displayed and demonstrated at the Sanborn Company Booth No. 17. Demonstrations and/or data will also be available on Sanborn instruments for biophysical research—single and multi-channel recording systems, monitoring oscilloscopes and physiological transducers.

Qualified Sanborn representatives will be pleased to answer questions and assist you with technical problems.

Sandoz Pharmaceuticals **Booth No. 22**
Hanover, N. J.

Sandoz Pharmaceuticals cordially invites you to visit our display at Booth 22.

MELLARIL—the first selective phenothiazine exhibiting potent tranquilizing activity without anti-emetic action. The greater toleration, notably relative absence of extra pyramidal symptoms, enhances its usefulness in management of major and minor emotional disorders.

PLEXONAL — preferred daytime sedative-relaxant.

SYNTOCINON NASAL SPRAY (new)—for intranasal application of synthetic oxytocin (Syntocinon). Activates the milk ejection reflex to stimulate milk let-down. Overcomes some of the complications associated with lactation e.g. engorged, painful, tender or distended breasts due to milk retention and stasis or the circumscribed, painful induration of incipient mastitis. Accelerates involution of the uterus.

W. B. Saunders Company **Booth No. 1**
Philadelphia 5, Pa.

Of the Saunders titles to be published this year these have special clinical appeal—Edwards: An Atlas of Acquired Diseases of the Heart; Beckman: Pharmacology; Pillsbury et al: Cutaneous Medicine; the new Current Therapy 1961; and Nagan: A Medical Almanac.

Schering Corporation **Booth No. 18**
Bloomfield, N. J.

Members of the Michigan Clinical Institute are cordially invited to visit the Schering booth where the following products will be featured: Fulvicin, the first oral antifungal antibiotic for ringworm; Rela, a new muscle relaxant-analgesic that eases sprains, strains and low back pains; Alpen, the new synthetized oral penicillin; and Naqua, effective new oral diuretic—and antihypertensive.

Julius Schmid, Inc. **Booth No. 26**
New York, N. Y.

An interesting and informative exhibit featuring IMMOLIN Vaginal Cream-Jel for use without a diaphragm; RAMSES Flexible Cushioned and BENDEX diaphragm; RAMSES Vaginal Jelly; VAGISEC Jelly and Liquid for vaginal trichomoniasis therapy; and XXXX (FOUREX) Skin Condoms, RAMSES, SHEIK and ESQUIRE Rubber Condoms for the control of trichomonal re-infection.

G. D. Searle & Company **Booth No. 69**
Chicago, Ill.

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Smith, Kline & French Labs. **Booth No. 19**
Philadelphia, Pa.

SK&F features (1) new 'Coplexen' Liquid, for symptomatic control of the cold complex in children; (2) Ornade® Spansule® capsules, the unique oral nasal decongestant for symptomatic treatment of upper respiratory distress; (3) Stelazine®, a specific anti-anxiety agent that helps restore emotional stability without soporific effect; and (4) Eskatrol® Spansule® capsules, for daylong control of appetite and relief of the psychic stress that causes overeating.

Smith, Miller & Patch, Inc. **Booth No. 38**
New Brunswick, N. J.

Smith, Miller & Patch, Inc., features TRULASE . . . the only chewable digestive aid designed to PREVENT pain and discomfort of gas and distension due to indigestion. Acts physiologically without delay. Contains three essential enzymes, standardized to assure dependable activity.

VITRON-C . . . a new oral hematinic, ferrous fumarate with ascorbic acid. Vitron-C has been clinically proven to be effective in treating iron deficiency anemia in patients with gastrointestinal irritability, or ulcerative disease. A chewable pleasantly flavored sugar-free tablet that offers iron with maximum toleration.

BISTRIMATE—A safe, effective and economical therapeutic to combat subacute, chronic or recurrent sore throats. Preliminary tissue studies indicate Bistrimate has an antiviral effect on Adenovirus type 3 and Adenovirus type 7.

E. R. Squibb & Sons **Booth No. 5**
New York, N. Y.

E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the Medical Profession in new products or improvements in products already marketed. At Booth No. 5, we are pleased to present up-to-date information on these advances for your consideration.

The Stuart Company **Booth No. 9**
Pasadena, Calif.

A cordial invitation is extended to all members and guests attending this meeting to visit the Stuart Company booth. Specially trained representatives will be in attendance to answer your questions on new products developed in our new and modern laboratories which have received international acclaim.

S. J. Tutag & Company **Booth No. 54**
Detroit, Mich.

S. J. Tutag & Company introduces a new anti-obesity agent for prompt and emphatic hunger control—with little if any central nervous system stimulation.

CYDRIL is a new chemical compound that possesses anoretic action with low toxicity. *CYDRIL* is available in two forms, tablets and the sustained-release Tutag Granucaps.*

Adults and children over 12 years, one *CYDRIL* tablet three times daily, preferably ½ hour before meals, or one *CYDRIL* Granucap* in the morning.

*Granucap—T. M. Reg. U. S. Pat. Off.

The Upjohn Company **Booth No. 16**
Kalamazoo, Mich.

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

U. S. Vitamin & Pharmaceutical Corp. **Booth No. 46**
New York, N. Y.

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March 8, 9, 10, 1961

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(Listed by Booth Number)

Booth No.		
1	W. B. Saunders Company	Philadelphia, Pa.
2	Hack Shoe Company	Detroit
3	Michigan Medical Service	Detroit
4	Encyclopedia Americana	Grand Rapids
5	E. R. Squibb & Sons	New York, N. Y.
6	S. H. Camp & Company	Jackson
7	J. B. Lippincott Company	Philadelphia, Pa.
8	Pet Milk Company	St. Louis, Mo.
9	The Stuart Company	Pasadena, Calif.
10	Randolph Surgical Supply Company	Detroit
11	Randolph Surgical Supply Company	Detroit
13	Desitin Chemical Company	Providence, R. I.
14	Roche Laboratories	Nutley, N. J.
15	Barry Laboratories, Inc.	Detroit
16	The Upjohn Company	Kalamazoo
17	Sanborn Company	Waltham, Mass.
18	Schering Corporation	Bloomfield, N. J.
19	Smith, Kline & French Laboratories	Philadelphia, Pa.
20	MSMS Life, Health & Accident Insurance Program	Lansing
21	Merck Sharp & Dohme	West Point, Pa.
22	Sandoz Pharmaceuticals	Hanover, N. J.
23	R. J. Reynolds Tobacco Company	Winston-Salem, N. C.
24	Pfizer Laboratories	Brooklyn, N. Y.
25	Atlas Pharmaceutical Laboratories, Inc.	Detroit
26	Julius Schmid, Inc.	New York, N. Y.
28	Lederle Laboratories	Pearl River, N. Y.
29	C. A. Fisher & Sons	Toledo, Ohio
30	A. Kuhlman & Company	Detroit
31	Marion Laboratories, Inc.	Kansas City, Mo.
32	Medical Protective Company	Fort Wayne, Ind.
33	Milex Products	Oak Park
34	Encyclopaedia Britannica	Detroit
35	Marshall Erdman & Associates	Madison, Wis.
36	Ortho Pharmaceutical Company	Raritan, N. J.
37	Ross Laboratories, Inc.	Columbus, Ohio
38	Smith, Miller & Patch, Inc.	New Brunswick, N. J.
39	Fuller Pharmaceutical Company	Minneapolis, Minn.
40	Parke, Davis & Company	Detroit
41	Parke, Davis & Company	Detroit
42	Eaton Laboratories, Inc.	Norwich, N. Y.
43	Abbott Laboratories	North Chicago, Ill.
44	Geigy Chemical Corporation	Yonkers, N. Y.
45	The Rupp & Bowman Company	Highland Park
46	U. S. Vitamin & Pharmaceutical Corporation	New York, N. Y.
47	American Cyanamid Company	Danbury, Conn.
48	Medco Products Company	Tulsa, Okla.
49	Doho Chemical Corporation	New York, N. Y.
50	Wm. S. Merrell Company	Cincinnati, Ohio
51	Edison Voicewriter	West Orange, N. J.
52	Ayerst Laboratories	Chicago, Ill.
53	E. Fougera & Company, Inc.	Hicksville, N. Y.
54	S. J. Tutag & Company	Detroit
55	Ferndale Surgical, Inc., Division J. F. Hartz Company	Ferndale
59	Lloyd Brothers, Inc.	Cincinnati, Ohio
60	A. S. Alce Company	St. Louis, Mo.
61	Eli Lilly & Company	Indianapolis, Ind.
62	Meyer & Company	St. Clair Shores
63	Coca-Cola Company	Atlanta, Ga.
64	Coca-Cola Company	Atlanta, Ga.
65	G. A. Ingram Company	Detroit
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67	Maico Hearing Service	Detroit
69	G. D. Searle & Company	Chicago, Ill.
70	Mead Johnson & Company	Evansville, Ind.

HEART BEATS

(This material is provided by the Michigan Heart Association)

Public Forum Launches Lay and Scientific Programs for "Michigan Heart Days"—February 10 and 11

The initial event marking "Michigan Heart Days" will be a program for the general public at 7:30 p.m., Friday, February 10, at the Rackham Auditorium in Detroit.

The program, sponsored by the Southeastern Region of the Michigan Heart Association, will include a talk, "How to Have a Heart Attack," by Richard Bates, M.D., Lansing, a showing of a short film on open heart surgery, and a "Doctors Meet the Press" panel discussion. Joseph G. Molner, M.D., Director of the Detroit and Wayne County Health Departments, will moderate the panel composed of Drs. Warren B. Cooksey, Park W. Willis, III, B. I. Johnstone, E. A. Irvin and Richard Bates. The panelists' presentations on hypertension, drugs and research, rheumatic heart disease, rehabilitation, and coronary heart disease, respectively, will be followed by an open question period by members of the Detroit press.

Scientific Program Panels Set

The first afternoon panel on "Hypertension" will be moderated by Richard Bing, M.D., of Wayne State University, Detroit. Sibley Hoobler, M.D., of the University of Michigan Medical Center, Ann Arbor, will join the morning session speakers on this panel.

The second panel, "Current Status of Open Heart Surgery," will be led by Dr. Nadas and will include Drs. F. D. Dodrill, S. Prescott Jordan, Jr., Conrad R. Lam, Richard R. Rasmussen and Herbert Sloan. The program timetable is listed below.

Scientific Sessions—February 11

Ballroom, Statler-Hilton Hotel, Detroit

Morning Session—9:00 A.M.

Alexander S. Nadas, M.D., Children's Hospital, Boston

"Clinical Diagnosis of Congenital Heart Disease"

Edward D. Freis, M.D., Veterans Administration Hospital, Washington, D. C.

"Hypertension"

Charles K. Friedberg, M.D., Mount Sinai Hospital, New York

"Diuretics"

Luncheon—12:15 P.M.

Luncheon and Annual Meeting of Members, Michigan Room

Afternoon Session—2:00 P.M.

PANEL: "Hypertension"

Moderator: Richard Bing, M.D., Wayne State University, Detroit

Edward D. Freis, M.D., Washington, D. C.

Charles K. Friedberg, M.D., New York

Sibley Hoobler, M.D., University of Michigan Medical Center, Ann Arbor

Alexander S. Nadas, M.D., Boston

PANEL: "Current Status of Open Heart Surgery"

Moderator: Alexander S. Nadas, M.D., Boston

F. D. Dodrill, M.D., Harper Hospital, Detroit

S. Prescott Jordan, Jr., M.D., Wayne State University College of Medicine, Detroit

Conrad R. Lam, M.D., Henry Ford Hospital, Detroit

Richard R. Rasmussen, M.D., Blodgett Hospital, Grand Rapids

Herbert Sloan, M.D., University of Michigan Medical Center, Ann Arbor

American Medical Association Fourteenth Clinical Meeting

The Fourteenth Clinical Meeting of the American Medical Association took place in Washington, D. C., November 28 to December 1, 1960. Following the precedent of many years, several special subjects of interest to the medical profession and the public were presented at conferences. Medicine's special interest in athletics again was highlighted:

Boxing may die out as a major sport in this country unless more properly-trained instructors are produced to teach fighters the art of self-defense, the second national conference on the Medical Aspects of Sports was told.

A panel of physicians and other experts on boxing agreed that most fighters now are not receiving adequate teaching. "Only a handful of men in even the largest cities can properly teach boxing," declared Dr. Max M. Novich, Newark, N. J. "There are no deaths in the ring where the boxers are properly trained," he told the audience of physicians.

Dr. Novich noted that old-time fighters such as John L. Sullivan, Jim Corbett, Jack Johnson, Jack Dempsey and Gene Tunney were scarcely marked by their ring experience. "There must be a return to the old school of scientific boxing which is almost non-existent today," said Dr. Novich.

Football and boxing were the main subjects at the conference which was sponsored by the American Medical Association.

The House of Delegates is the legislative policy-making body of the Association, each state being given a number of delegates according to membership. The various sections and the governmental groupings also have delegates. The business of the Association is conducted through many sources: reports of standing committees, Councils, Officers, et cetera, are made and referred to ten reference committees who have been previously appointed. Resolutions are a method of introducing business. These are referred to certain designated reference committees who hold open hearings at published places and times. Anyone wishing may appear before the reference committee and submit his arguments. It is hoped all argument will thus be presented and considered in committee. After all argument and everyone is heard, the reference committee goes into executive session, makes its decisions, and writes a report. This report is presented to the House of Delegates at a specified time where it may again be argued, but usually is amended or accepted piecemeal. This method has been in operation many years and always produces a satisfactory answer—or action is postponed.

At this session, thirty resolutions were presented, mimeographed and studied. Some committees worked into the small hours, then dictated their reports which were to be mimeographed and given to the House of Delegates members, alternates, and certain other interested persons.

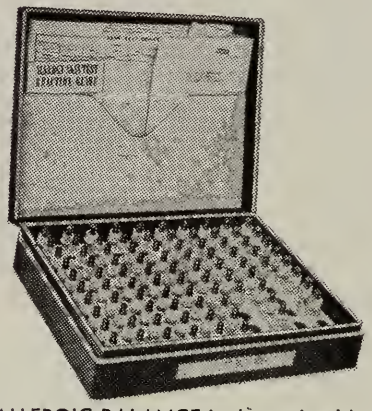


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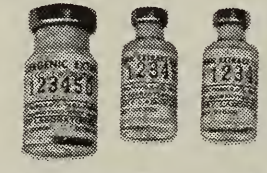
How to restore your patient's allergic balance the "classic" way . . . use specific desensitization for

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We are indebted to F. J. L. Blasingame, M.D., AMA Executive Vice President, for the following summary of accomplishments.

A scholarship and loan program for medical students, the status of foreign medical graduates, an AMA membership dues increase, the expansion of voluntary health insurance, health care for the aged and new developments in polio vaccine were among the major subjects acted upon at the Fourteenth Clinical Meeting held in Washington, D. C., November 28-December 1.

Named as 1960 General Practitioner of the Year was 44-year-old James T. Cook, M.D., of Marianna, Florida, who was selected for his dedication to both medical practice and service to the community. Dr. Cook is the fourteenth recipient of the award.

Speaking at the Monday opening session, E. Vincent Askey, M.D., of Los Angeles, AMA President, called upon the delegates to support not only existing AMA programs but also expansion of new programs necessary to meet the challenges of society. Dr. Askey assured the new administration in Washington of cooperation whenever and wherever possible but emphasized that the AMA will not change its policies merely for the sake of conformity.

Total registration reached 8,170, made up of 3,940 physicians and 4,239 guests.

Scholarship and Loan Program

The House of Delegates approved a scholarship and loan program proposed by the Special Study Committee of the Council on Medical Education and Hospitals, and also urged that there shall be local participation in the program at the state and county level. In commenting on the two-part program, the House approved the following statement by the reference committee:

"This proposed program will provide concrete evidence of the American Medical Association's sincere desire to attract increasing numbers of well qualified young people to enlarge the ranks of our profession. Your reference committee recognizes that the program is wisely designed to allow for its enlargement through the support of individual physicians and other groups. Your reference committee was impressed with the enthusiastic support of this proposal indicated during the course of the discussion. There was indicated a desire that in the final formulation of the administrative details of this program, provision be made for widespread participation by individual physicians as well as county and state medical societies. The program will clearly assist in securing highly talented individuals whose ability and leadership in all areas of medicine will be fostered and at the same time will bring needed financial assistance on a broad basis to medical students under a system in keeping with this Association's belief in individual responsibility."

Foreign Medical School Graduates

Meeting the problem of foreign medical graduates, the House of Delegates adopted a report which included the following statement:

(Continued on Page 112)

NaClex®

benzthiazide

a new diuretic with an unsurpassed faculty for salt excretion



as salt goes, so goes edema

A basic principle of diuresis is that "increased urine volume and loss of body weight are proportional to and the osmotic consequences of loss of ions."[1]

Robins' new NaClex is a potent, oral, non-mercurial diuretic that helps reduce edema through the application of this fundamental principle. It limits the reabsorption of sodium and chloride in the renal proximal tubules (*with a relative sparing of potassium*). The body's homeostatic mechanism responds by increasing the excretion of excess extracellular water. Thus the NaClex-induced removal of salt leads to a reduction of edema.

a unique chemical structure

NaClex (benzthiazide) is a new molecule which provides a "pronounced increase in diuretic potency"[2] over its antecedent sulfonamide compound. Compared tablet for tablet with current oral diuretics, it is unsurpassed in diuretic potency.

twofold value

NaClex produces diuresis, weight loss, and symptomatic improvement in edema associated with various conditions. It also has antihypertensive properties and may be used alone in mild hypertension or with other antihypertensive drugs in severer cases.

For complete dosage schedules, precautions, or other information about NaClex, please consult basic literature, package insert, or your local Robins representative, or write to the A. H. Robins Co., Inc

Supply: Yellow, scored 50 mg. tablets.

References: 1. Pitts, R. F., Am. J. Med., 24:745, 1958. 2. Ford, R. V., Cur. Therap. Res., 2:51, 1960.

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(Continued from Page 110)

"In order that those foreign physicians who have not yet been certified by the Educational Council for Foreign Medical Graduates might be given further opportunity to enhance their medical education, hospitals would be encouraged to develop special educational programs. Such programs must be of educational worth to the foreign graduate and must divorce him from any responsibility for patient care. Foreign physicians may participate in these programs until June 30, 1961, with approval of the Department of State so that their exchange visa will not be withdrawn before that time. This will also allow the non-certified foreign physician the opportunity to take the April, 1961, Educational Council for Foreign Medical Graduates examination."

AMA Dues Increase

The House approved a Board of Trustee report which announced that a dues increase would be recommended at the annual meeting in June, 1961. The report indicated that the amount would be not less than $10 and not more than $25 to be effective January 1, 1962. The Reference Committee asked the Board to consider an increase in the annual dues of $20.00, to be implemented over a period of two years: $10.00 on January 1, 1962, and $10.00 additional on January 1, 1963.

The House suggested that these funds be used to inaugurate or expand a number of programs including:

1. Financial assistance to medical students.
2. Continuing education for practicing physicians.
3. Health advice to the lay public.
4. Medical research.
5. The expansion by the Communications Division of its program of faithfully portraying the image of the American Medical Association.

It is important, the House emphasized, that the Board of Trustees report recommending a dues increase be transmitted in essence to the grass roots level.

Voluntary Health Insurance

In place of a Board of Trustees report and three resolutions, the House adopted the following substitute resolutions:

"WHEREAS, It has been widely recognized that voluntary health insurance is the primary alternative to a compulsory governmental program; and

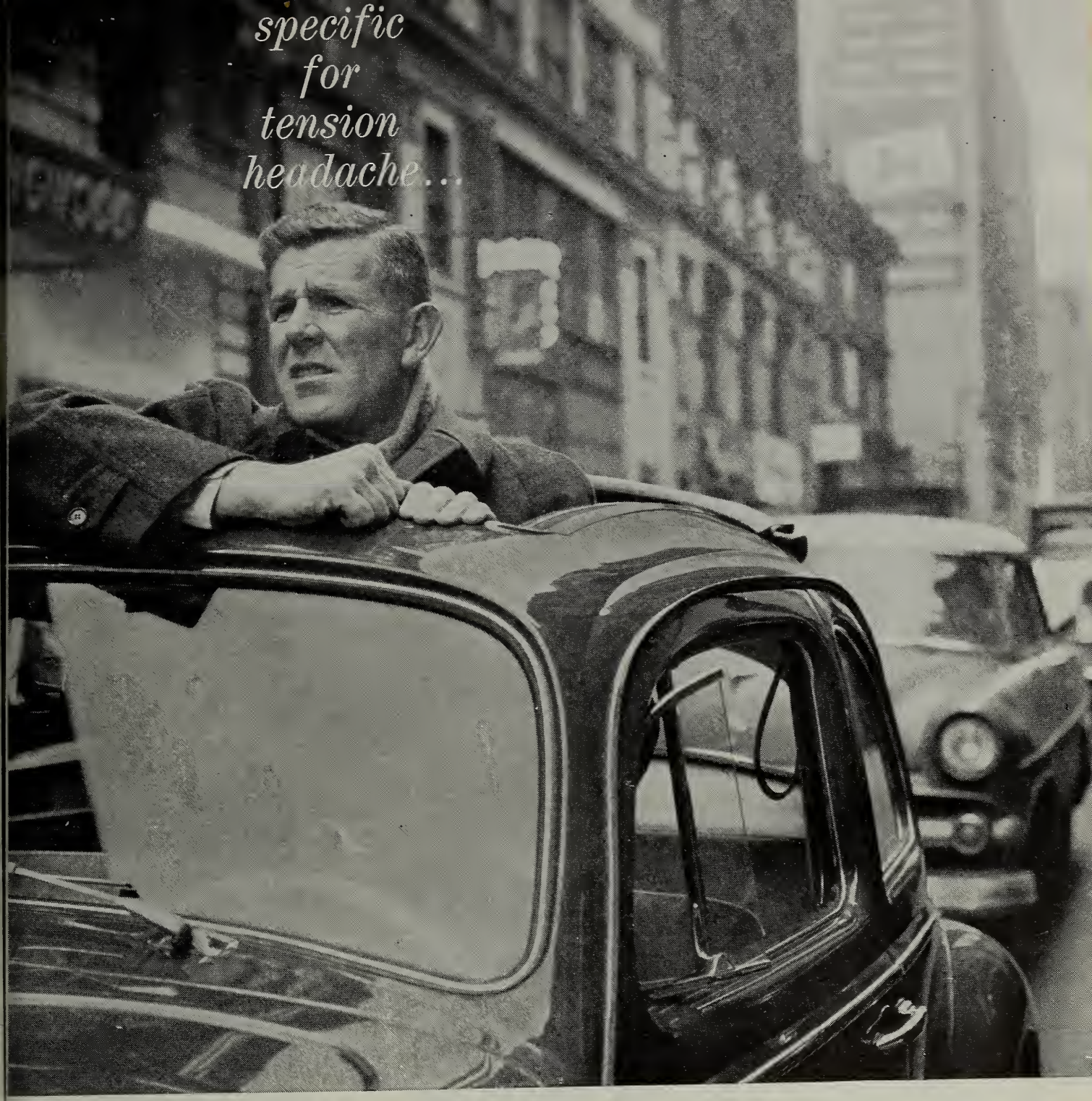
"WHEREAS, The public has shown its confidence in this voluntary system; and

"WHEREAS, Current social, political and economic developments compel a new and revitalized effort to make voluntary health insurance successful; and

"WHEREAS, the American Medical Association has consistently pledged itself to make available the highest type of medical care; therefore be it

"RESOLVED, that the House of Delegates direct the Board of Trustees and the Council on Medical Service to assume immediately the leadership in consolidating the efforts of the American Medical Association with those of the National Association of Blue Shield Plans, the American Hospital Association and the Blue Cross Association into maximum development of the voluntary, non-profit prepayment concept

(Continued on Page 114)



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relieves pain,
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nervous tension

rapid action • non-narcotic • economical

"We have found caffeine, used in combination with acetylsalicylic acid, acetophenetidin, and isobutylallylbarbituric acid, [Fiorinal] to be one of the most effective medicaments for the symptomatic treatment of headache due to tension."

Friedman, A. P., and Merritt, H. H.: J.A.M.A. *163*:1111 (Mar. 30) 1957.

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New Form — Fiorinal Capsules

Each contains: Sandoptal (Allylbarbituric Acid N.F. X) 50 mg. (3/4 gr.), caffeine 40 mg. (2/3 gr.), acetylsalicylic acid 200 mg. (3 gr.), acetophenetidin 130 mg. (2 gr.).

Dosage: 1 or 2 every four hours, according to need, up to 6 per day.

SANDOZ

(Continued from Page 112)

to provide health care for the American people; and be it further

"RESOLVED, that similar leadership be undertaken to coordinate the efforts of private insurance carriers through conferences with their national organizations; and be it further

"RESOLVED, That, where feasible, efforts be made to cooperate with representatives of other types of medical care plans, other professional groups, and representatives of industry, labor and the public at large."

Health Care for the Aged

The House reaffirmed the Association's support of the Kerr-Mills Bill, which was passed last summer, and its opposition to any legislation involving the use of the OASDI mechanism for medical aid to the aged. The delegates also urged all state and local medical societies to cooperate with the appropriate state officials and provide leadership in implementing the provisions of the Kerr-Mills Bill.

In connection with health care for the aged, the House suggested further experimentation in home care programs, homemaker services and visiting nurse services. The delegates also recommended an increased emphasis at all levels of medical education on the new challenges being presented to physicians in the health care of older persons.

Polio Vaccine

The House agreed with a Board of Trustees report which said:

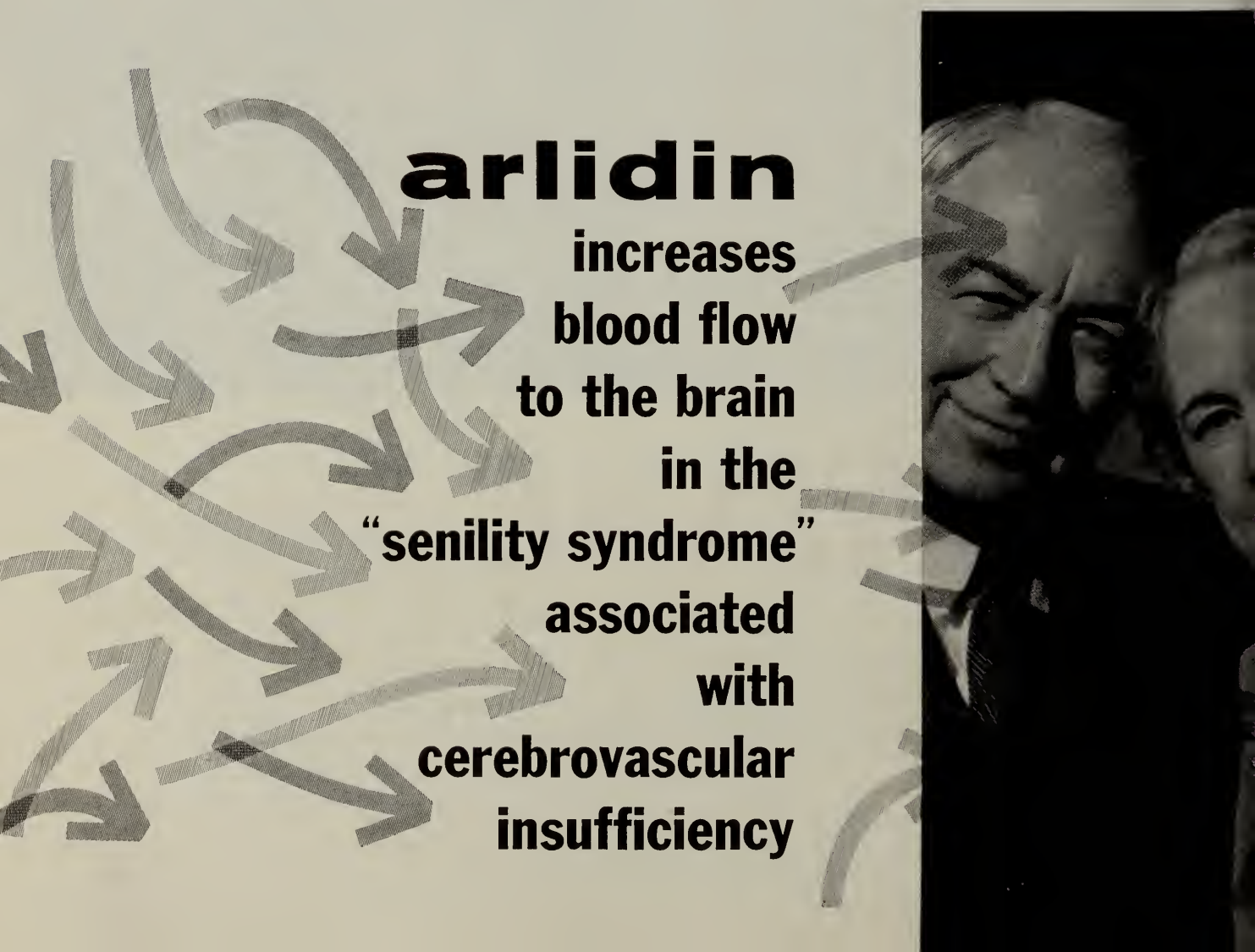
"In view of the fact that oral polio vaccine will not be generally available in sufficient quantity in 1961 for any large scale immunizing effort, the Board of Trustees of the AMA strongly recommends that the medical profession encourage the widest possible use of the Salk vaccine for the prevention of poliomyelitis. The Salk vaccine has been proved to be effective and since there are still many segments of the population not immunized against poliomyelitis every effort should be made to encourage the general public to take advantage of the Salk vaccine without delay."

The Board report was amended to suggest that a proper committee be established by the AMA to study the problems involved in administration of the new oral polio vaccine and to establish guides for physicians to follow when they are approached by various groups and asked for their support in administering oral polio vaccine.

Miscellaneous Actions

In considering a wide variety of resolutions and annual and supplementary reports, the House also:

Approved continuing study and periodic re-evaluation of the trend toward locating *physician's offices* in or adjacent to hospitals;



Directed the Committee on Medical Care for Industrial Workers to carry out its duties as previously instructed and to prepare guides for physician relationships with *medical care plans* in conformity with the clear policies already laid down by the House of Delegates;

Approved a set of guides relating to drug expenditures for *welfare recipients*;

Asked the Board of Trustees to study the question of blood replacement responsibility and also the matter of establishing health insurance fee schedules for *surgical assistants*;

Urged the Board to make every effort to reduce the number of physicians who are non-dues-paying members and approved a three-year study report on the relationships of *physicians not-in-private-practice* to organized medicine;

Requested the Board to present a completed *retirement* and *disability* insurance program for AMA members at the June, 1961, meeting, and

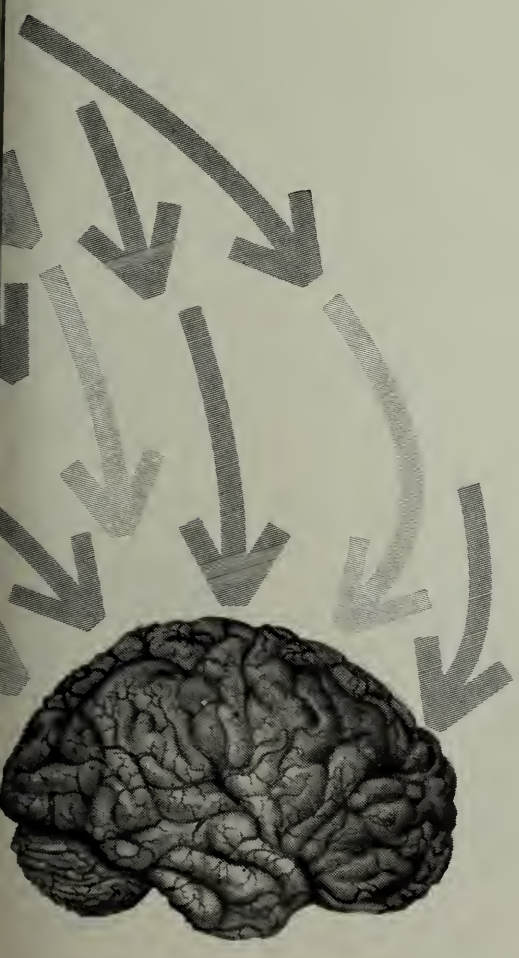
Agreed that the *General Practitioner of the Year* Award should be continued as at present.

* * *

Michigan members attended in sufficient numbers to make a noticeable showing. All delegates and alternates were there save one. Many of the officers and administrative officers also attended. R. L. Novy is a member of the Council on Medical Service; William A. Hyland is chairman of the Standing Committee on Constitution and ByLaws. Geo. W. Slagle served on the Reference Committee on Miscellaneous Business, and O. J. Johnson on the Committee on Rules and Order of Business.

In the scientific program, several Michigan physicians took part: "Fractures"—Sydney N. Lyttle, M.D., M. R. Sullivan, M.D., and F. V. Wade, M.D., Flint; "Space: Do You Have a Question?"—John W. Sigler, M.D., Detroit; "Diagnosis of Shoulder Pain"—J. L. Fleming, M.D., R. S. Knighton, M.D., J. W. Sigler, M.D., Wm. C. Noshay, M.D., Ford Hospital; "Evaluation of Urinalysis"—E. M. Knights, Jr., M.D., G. M. Longfield, M.D., D. M. Holland, M.D., Flint; "Obesity"—F. P. Rhoades, Detroit; "Heart-Lung Machine"—S. I. Lerman, Detroit.

One could not attend these meetings without marveling at the concentration and dedication shown, and the evident, almost universal belief that the medical profession is again facing staggering problems which must be resolved unless we collectively lose our treasured right of independent, non-controlled practice. Almost every discussant, especially in the Insurance and Medical Service Committee, expressed the firm conviction that now, if ever, the profession must settle its misunderstandings and face a determined



Inadequate cerebral blood flow—often due to cerebral arteriosclerosis—may result in the "senility syndrome" with its pattern of mental confusion, memory lapses, depression, fatigue, apathy and behavior problems.[1-3]

43% increase in cerebral blood flow with Arlidin[4]

In patients with cerebrovascular insufficiency, Eisenberg[4] measured a 43 percent increase in blood flow in the brain following administration of Arlidin orally for more than two weeks beginning with a dosage of 12 mg. t.i.d. and increasing to 18 mg. t.i.d. There was a decrease in cerebral vascular resistance in most instances.

Winsor and associates[3] found Arlidin "of particular value clinically in relieving some of the symptoms of cerebral vascular insufficiency (vertigo, lightheadedness, mental confusion, diplopia)."

Arlidin is a unique and dynamic vasodilator which acts to increase circulation in the brain...in the inner ear and eye...also in the peripheral skeletal muscle.

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references: 1. Madow, L.: Penn. M. J. 62:861, June 1959. 2. Stieglitz, E. J.: Geriatric Medicine, ed. 2, Philadelphia, Saunders, 1949 p. 274. 3. Winsor, T., et al.: Amer. J. Med. Sciences 239:594, May 1960. 4. Eisenberg, S.: ibid, July 1960.

Literature giving indications, dosage, precautions, etc. available on request.

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Vials: 10 cc., singly and in boxes of three.
Ampuls: 1 cc. and 2 cc., in boxes of 12 and 100.
(Each cc. of NUMORPHAN* contains 1.5 mg. oxymorphone as the hydrochloride.)
Suppositories: 2 mg. and 5 mg., in boxes of 6.

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"Force" which would change our whole concept of work.

Selective Service Directive Clarified

The National Advisory Committee to the Selective Service System indicates a clarification of the Classification of Interns and Residents in a directive issued October 21, 1960.

"Local boards should continue to give serious consideration to the deferment in Class II-A of a registrant who is a physician in order that he may complete up to one year of internship. He should not be placed in Class II-A for the purpose of completing a residency unless (1) in the opinion of the local board his services are absolutely essential to the operation of the hospital, or (2) he is one who has been certified for essential training by the Public Health Service on its form PHS 2524."

This eliminates reference to physicians who are reserve officers participating in the Armed Forces Reserve Commissioning and Residency Programs.

WMA Elects Brazil M.D.

Antonio Maniz Aragao, M.D., of Brazil, was chosen as president-elect at the 14th General Assembly of the World Medical Association at Germany. Installed as the new president was Paul Eckel, M.D., of Germany.

Gunnar Gundersen, M.D., Madison, Wis., of the United States, is chairman of the Council of the WMA.

Conquest of the World

Such a social organization produces a fever of envy so violent, a straining of minds toward ambition so constant, that by now the Russian people must be inept in everything except the conquest of the world. I always come back to this term because such a goal is the only thing that can explain the excessive sacrifices imposed here on the individual by society. If inordinate ambition dries up the heart of man, it can also exhaust the minds and delude the judgment of a nation to the point of making it sacrifice its liberty to victory. Without this ulterior design, admitted or not, which many men obey, perhaps in ignorance, the history of Russia seems to me an inexplicable enigma.—"Journey for Our Time," the MARQUIS DE CUSTINE'S "Russia in 1839," translated by PHYLLIS PENN KOHLER.

Second MAP Congress Slated For Detroit, February 22-24

Michigan doctors will join with members of other professions to take a serious look at themselves—their past, present and future—when they meet at the Sheraton-Cadillac Hotel in Detroit, February 22, 23 and 24, 1961, for the 2nd Annual CONGRESS OF THE PROFESSIONS, annual meeting of the Michigan Association of the Professions.

Meeting with architects, dentists, engineers, lawyers, doctors of veterinary medicine and pharmacists, the M.D.'s will hear speakers of national importance discuss the achievements, evaluations, and challenges facing the professional man.

This year's event will run for three days, doubling last year's length. Programs will include committee hearings, discussion groups, inter-professional forums and other programs through which an exchange of ideas can be promulgated. Of particular interest will be the programs on which each of the seven professions will defend, or justify, itself to the other six. The group of speakers heading the program reads like a list of nominees for the nation's twenty most distinguished people.

All eligible professional men and women in the state will be issued invitations to attend but only MAP members in good standing will be eligible to vote for new Board members and transact other official business.

It is anticipated that many professional people from other states will be present to discuss plans for an AMERICAN ASSOCIATION OF THE PROFESSIONS which was incorporated early this year.

Aid MMS Communication

More than 100 Michigan Medical Service Professional Relations Liaison Committees of county medical societies or hospital staffs now have been formed and are functioning as communication focal points.

The committees serve a dual purpose: to channel information from Blue Shield to hospital medical staffs, and to forward suggestions and ideas from medical staff members to Blue Shield for consideration and evaluation.

Re-elect MMS President



G. Thomas McKean, M.D., Detroit, has been re-elected president of the Michigan Medical Service. The annual meeting of the Blue Shield board was held in the fall following the election of directors during the MSMS annual session.

Elected to serve with Doctor McKean were George W. Slagle, M.D., Battle Creek, vice president; Max L. Lichter, M.D., Melvindale, secretary, and Waldo L. Stoddard, Grand Rapids, banker, treasurer.



MSMAP Seminar in March; Courses to Start

The Fourth Annual Educational Seminar of the Michigan State Medical Assistants Society will be held at Detroit, Thursday, March 9, 1961, in conjunction with the Michigan Clinical Institute. The morning-afternoon program will be held at the Pick-Fort-Shelby hotel.

Registration will begin at 9 a.m., first address at 10:15 a.m.

Donald N. Sweeney, Jr., M.D., Detroit, has been selected to give the L. Fernald Foster Memorial Lecture, speaking on "Medical and Professional Ethics in the Doctor's Office." The Michigan Bell Telephone Company film, "The Voice of Your Office," will be shown. Luncheon will be served at 12:15 p.m.

The afternoon speakers are Alfred Golden, M.D., Pathologist, of Jennings Memorial and Alexander Blain Hospitals, who will speak and show slides on "Understanding the Purpose of Clinical Laboratory Procedures," and William Ross Eyler, M.D., Dearborn, who will speak on "X-ray in Diagnosis and Treatment." To conclude the program, a second short Civil Defense movie will be shown, "The Invisible Enemy."

MSMAS Officers

Many activities are already underway for the Michigan State Medical Assistants Society for the new year.

New officers, elected at the annual meeting at Detroit, include Mrs. Betty Lou Willey, Port Huron, president, and Miss Cecile Rutan, Hanover, president-elect. Others include Mrs. Donna Fogal, Port Huron, corresponding secretary; Mrs. Vivian Branyan, Spring Lake, recording secretary, and Miss Helen Hawkins, Saginaw, treasurer. Mrs. Reta Stahl, Albion, is the past president.

Named ACS Official

Major General James Patrick Cooney, M.D., who retired recently from the U. S. Army, is now vice-president for medical affairs of the American Cancer Society. Before his retirement, General Cooney served as the U. S. Army's chief surgeon in Europe, stationed in Heidelberg, Germany. From 1955 to 1959, he was deputy surgeon general of the Army. The 57-year-old Major General is an outstanding medical officer, radiologist, and administrator.

It's Enrollment Time For Medical Assistants

Another series of inservice training courses for medical assistants will begin in February.

Courses in this excellent program will be held during the second semester at Battle Creek, Ann Arbor, Saginaw and Detroit.

This project was started in 1958 by the Extension Service of the University of Michigan and will be completed in Lansing and Jackson this month. The full training program consists of six semesters of work over a three-year period. The project, as was underwritten in part by a grant from the Kellogg Foundation, included courses in (1) Law and Economics in Medical Office Administration, (2) Medical Information for Medical Assistants, (3) Medical Office Management, (4) Nursing Information for Medical Assistants, (5) Psychology of Human Behavior, and (6) Dynamics of Human Behavior.

The courses are held in the evening so as not to interfere with the doctor's office routine. In most cases, the classes meet Thursday evenings in a classroom of the nurses home connected to the hospital for 16 two-hour sessions.

In many cases, the tuition cost of $36 is paid by the doctor as an incentive to his medical assistant. Sponsors of the project contend that doctors should actively urge their assistants to enroll for this invaluable training. They point out also that this educational undertaking will cease unless it is supported by the Michigan doctors of medicine and their medical assistants.

Eleven M. D. Placements

The following placements were made by the Health Council during September, October and November:

Placed by Michigan Health Council

Gordon H. Willoughby, M.D., Manistee
Morris Chelsky, M.D., Detroit

Assisted by Michigan Health Council

J. Clyde Spencer, M.D., Lansing
Charles K. Wortley, M.D., East Lansing
Carl H. Birkelo, M.D., Pontiac
Robert B. Marshall, M.D., Saginaw
James H. Park, M.D., Owosso
Carlos M. Aquino Sosa, M.D., Warren
George A. Voikos, M.D., Muskegon
James A. Kiley, M.D., Onekama (temporary)
Karl Heinz Roehl, M.D., Dearborn



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MICHIGAN DEPARTMENT OF HEALTH

ALBERT E. HEUSTIS M.D., State Health Commissioner

Highlights 1960—Part One

Familiarity, it is said, breeds contempt and absence makes the heart grow fonder. If we really believed this, we would immediately ask the editor to eliminate this page from the JOURNAL. We could then sit back secure in the knowledge that physicians in Michigan were all steadily growing fonder of the Michigan Department of Health because of the absence of our page in their journal. In fact, however, these, like many other old saws, have lost their cutting edge. We are anxious that physicians become familiar with us because we are confident that it will breed, not contempt, but understanding through recognition.

Many of our activities are directly related to the work of physicians throughout the state. Unfortunately, it is seldom that any single physician has an opportunity to recognize and understand the extent of these activities. Therefore, in this and subsequent issues, we would like to highlight a few of them which are of particular interest to the medical profession. We begin with some highlights of the work of the Division of Laboratories.

Diagnostic Services

During the past year, this division performed about 1,903,000 diagnostic tests. These tests were made for physicians and health officers throughout Michigan and were done in the laboratories in Lansing, Grand Rapids, Houghton and Powers. These examinations covered a wide range of diseases including: diphtheria, scarlet fever, typhoid, Shigella infections, Salmonella infections, undulant fever, syphilis, gonorrhea, tuberculosis, pertussis, tularemia, fungus infections, streptococcal infections, anaerobic infections, parasitic infections, Rickettsial infections, rabies, psittacosis, poliomyelitis, the encephalitides, and transudates and exudates from various parts of the body.

Crime Diagnostic Service

This activity involves the laboratory examination of specimens submitted by law enforcement agencies in the state as a part of the investigation of suspected crimes. Examinations are made on specimens relating to the following: alcoholic intoxication, paternity disputes, narcotics, identification of blood stains, poisoning, arson, identification of hair, fibers, seminal stains, paint and enamel, carbon monoxide poisoning, identification of tool marks and skeletal remains, etc. During the past year, 17,900 crime examinations were performed.

Biological Products

Biological products are manufactured for the prevention, diagnosis, or treatment of communicable diseases. These products have been distributed to the physicians of the state for 39 years and are provided without charge. During the past year, an estimated 5,473,464 doses of serums and vaccines have been distributed. Products are provided for the following diseases: diphtheria, influenzal meningitis Type B, histoplasmosis, whooping cough, rabies, gonorrheal ophthalmia, smallpox, tetanus, tuberculosis, typhoid fever, and paratyphoid fever. These products are produced under license from the National Institutes of Health.

Blood Fractions

Blood fractions are provided for the following diseases or clinical situations: afibrinogenemia, aggammaglobulinemia, German measles, hemophilia, hypoproteinemia, hemorrhagic situations, infectious hepatitis, and measles. Blood fractions presently distributed include: gamma globulin, antihemophilic globulin, fibrinogen, and albumin.

Antibiotics

Research continues in the development of new and useful antibiotics and anti-cancer agents. A total of 11,611 samples of these substances has now been submitted to the National Cancer Institute, for screening against cancer cells. Of these, 75 substances have shown marked anti-cancer activity. Four are now being developed for more advanced investigations.

Water and Milk

A record number of water and milk samples were received by the laboratories last year. A total of 79,026 samples were received which required 156,000 chemical and bacteriological examinations.

New services during the year include the analysis of water for anionic synthetic detergents and the examination of milk for antibiotic residuals.

Next month, we will highlight the activities of other divisions including the extensive work done with regard to mass screening examinations for various diseases including diabetes, cervical cancer, and tuberculosis.

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Obstetrical Brevits

(This column is sponsored by the Michigan Society of Obstetrics and Gynecology)

Cancer of the uterine cervix complicating pregnancy is rare enough (one case in 3,000 to 5,000 pregnancies) that it appears only seldom in any individual practice. It is, perhaps, this very element of rarity that makes it so potentially dangerous.

The diagnosis is all too often delayed for a few critical weeks or months because it is simply not brought to mind until the lesion is so obvious that the possibility can no longer be ignored. This is usually at a stage sufficiently advanced to make cure difficult, if not impossible.

If one does not constantly consider the possibility, remote though it may seem, there are a number of opportunities for diagnostic error.

Take, for example the problem of cervical erosion. In a nonpregnant patient, a cervix which bleeds on sponging is certainly going to be given the benefit of further investigation; cytologic study, at the very least, and often multiple biopsies. On the other hand, an ectoplasia in a pregant patient bleeds frequently enough that such a finding may not be accorded more than a lingering look.

Yet there is nothing about the *gross appearance* of such a cervix which can possibly allow one to exclude the possibility of an early carcinoma.

This tendency to accept the probable as the positive goes further. In the pregnant patient, as in the nonpregnant, scant painless vaginal bleeding heads the list of initial symptoms of cervix cancer. Yet a patient with vaginal spotting in the early months of pregnancy is, if one considers simple probability, most likely to be threatening to abort and thus is very likely to be instructed to "take it easy" and, perhaps, to abstain from intercourse. This may frequently be a good way to make a threatened abortion patient stop bleeding; but it is also most certain to make an early cervix cancer stop bleeding as well.

All too often, unfortunately, this sort of result is felt to prove the diagnosis of threatened abortion. If the patient "takes it easy," she will probably continue to be safe—always provided that she doesn't have the cancer instead. The only way one can be certain is to re-evaluate the cervix, yet often this is not done.

Is this potential delay really a serious practical problem? The facts indicate that it is. In 60 cases of cervix cancer complicating pregnancy, seen at the University of Michigan Medical Center over a period of almost 25 years, 55 of the patients presented just such a picture. They were pregnant, experienced painless vaginal bleeding, and yet wasted an average of over four and a half months before the diagnosis was finally made.

In virtually all cases, this was physician delay. Furthermore, the delay was costly. Forty-one of these patients had progressed to an advanced stage (International Stage II or greater) before they were diagnosed. Of these forty-one, only eight survived, though all were treated fully and quickly after the diagnosis was once proved.

Whether or not pregnancy *per se* contributes to a more rapid extension of the malignancy is a point which has occasioned some discussion. Our own material would seem to suggest that it does, but, if so, this only serves to make any delay in diagnosis that much more critical.

Delay might be minimized by considering the following steps as an integral part of good prenatal care:

1. Any change in the cervix should be evaluated critically at the time of the initial antepartum examination. Cytologic examination should be used liberally, if not routinely. Biopsy should also be used freely. It presents minimal hazard to the continuation of the pregnancy.

2. Any cervical erosion or ectoplasia which bleeds readily, even though initial histologic studies are negative, should be subjected to repeated scrutiny and cytologic or biopsy evaluation throughout pregnancy.

3. Vaginal bleeding at any point in pregnancy should not be dismissed until the cervix has been carefully inspected and, in all probability, cytologic or biopsy evaluation carried out. This rule should apply without regard to previously recorded "normal" examination of the cervix.

4. Sharp conization of the cervix, while more difficult during pregnancy, should be seriously considered whenever a biopsy is questionable or repeated cytologic smears are abnormal.

With early diagnosis of carcinoma, treatment presents no particular problems. Results seem best with irradiation, using both external sources and radium in a conventional manner. The handling of the fetus may depend on religious principles but from the strictly medical standpoint, the most important rule would seem to be that dilatation of the cervix should be carefully avoided. Whatever decision is made about the disposition of the pregnancy, this one consideration must be borne in mind.

In substance, then, the greatest problem in cervix cancer complicating pregnancy would seem to be delay in diagnosis. Much of this delay is avoidable and, as we improve this aspect of the problem, the survival rates should, at the very least, be as good as those in the parallel nonpregnant case.

JOHN R. G. GOSLING, M.D.
Ann Arbor



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Pathology Comment

These items are provided by the Michigan Pathological Society

Clinical Laboratory Standards

Recent publicity in New York concerning the existence of "cut-rate" laboratories and their use by physicians should serve to focus our attention on this situation in our own area. Pathologists, to whom clinical pathology is an integral part of the practice of medicine, have been most concerned about raising the standards of laboratory practice and maintaining them at the highest possible level. Those of us entrusted with the responsibility of supervising clinical laboratories know only too well how diligent supervision must be to preserve the reliability of laboratory data. Casual or even periodic inspection is no substitute for a properly organized control system.

It is a matter of some concern that our fellow physicians not infrequently make use of unsupervised, technician-run laboratories competing with each other and with pathologists-supervised laboratories solely on the basis of cost and availability. Even where the physician himself includes a laboratory in his office, the technician is often poorly trained and inadequately supervised, and the methods are often unreliable and even archaic. Who stands behind the laboratory work done on *your* patients? Ultimately, *you* assume that responsibility, of course. Can you state with confidence that a laboratory result is correct? Are you being fair to your patients, and to yourself?

Even the so-called "simple" laboratory tests frequently run in the doctor's office are often far more difficult to control and to interpret than most physicians realize. We have prepared a list of a few of the questions which you should be able to answer if you have assumed this responsibility. Can you answer them? If you have any doubts, you may write to Viola G. Brekke, M.D., Highland Park General Hospital, President of the Michigan Pathological Society, for an information sheet, or consult with your local pathologist.

CLINICAL PATHOLOGY QUIZ

Urinalysis

1. With commonly-used methods of ketone testing, you are not actually measuring acetonuria. What are you measuring?
2. With what do Clinistix and TesTape react? Is this a specific reaction? What interferes with it?
3. How sensitive are chemical tests for hematuria?
4. How common is ketonuria?
5. The ferric chloride reaction is often used for screening for phenylketonuria. How specific is this reaction?

Hematology

1. What is the method of measuring hemoglobin now adopted by most laboratories?
2. How reliable is the microhematocrit?
3. Is there such a thing as a hemoglobin of "100 per cent"?
4. What is the accuracy of a red blood cell count?
5. How are platelets counted?

Medical Technology

1. What is a registered medical technologist?
2. What training is required?
3. Who supervised the training program?
4. Are your laboratory tests performed by a registered medical technologist?

Basophilic Leukemia

An acute basophilic leukemia in the form of a stem-cell leukemia can be accepted only if a separate stem-cell is acceptable for each type of granulocyte. They would be difficult to distinguish because coarse granulation and basophilic staining would be typical of all the stem-cells. In ordinary chronic myelocytosis, all three types of granulocytes are involved, not uniformly, but, in comparison to the normal counts in blood and marrow, the basophilic granulocytes show the greatest increase. The ratio of basophils, eosinophils and neutrophils in normal blood is 1:6:130 and in marrow 1:10:187. In chronic myelocytosis, the increase in neutrophils in the blood is 34 to 40-fold, of the eosinophils 15-fold, and of basophils 140 to 150-fold. On the basis of a case report, the author shows that it may prove difficult to differentiate between myelocytosis and leukemoid reaction, because certain diseases, especially tuberculosis of the lymphopoietic system may produce leukemoid reactions, which are difficult to differentiate histologically from a true leukosis. The differentiation between basophilic leukemia and myelocytosis with chief involvement of the basophilic cells requires in addition puncture of spleen, liver and enlarged lymph nodes, or autopsy proof of systemic leukemic hyperplasia of the blood-forming organs. Such corroboration is missing in most reports on basophilic leukemia. — *Schweizerische medizinische Wochenschrift*, Basel, August, 1960.



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EDITORIAL OPINION

The Kind of Help That Counts

B. C. Enquirer and News, November 12, 1960

The Kellogg Foundation of Battle Creek has demonstrated again that it is one of this country's greatest private forces for better understanding and friendship between the United States and other nations. Its practical philanthropy in health, education and agriculture abroad can do more to maintain America's prestige than can all the politicians' promises ever uttered.

Thanks to a $97,850 grant from the foundation, the University of Concepcion in Chile has three of its professional schools back in operation after the disastrous earthquake of May 21. The schools, of course, are those most needed—medicine, dentistry and nursing.

This is the kind of friendly help that really counts. Given quietly and with no thought of personal or political gain, the foundation grant was made when it was needed most. The $97,850 involved is only a pittance when compared with the billions poured out by the United States government in foreign aid. In its effect, however, every dollar of the Kellogg grant is easily worth a thousand dollars of government foreign aid because it has gone where it truly will do the most good—and without cost to the taxpayers.

Medicine—and the Challenge of the '60's

National Association of Blue Shield Plans, November, 1960

Twenty years ago, our profession responded to an urgent challenge, and demonstrated that doctors—working together with labor, industry and community leaders—could solve a great social problem by voluntary effort.

The challenge we faced in 1940 was the threat of national compulsory health insurance, which many people then felt was the only practicable solution to the problem of prepayment for modern medical care.

Medicine's response was the creation of Blue Shield, through which our profession acknowledged its responsibility not only to provide good medical care but to help people pay for it when they need it. Although Blue Shield has always been the leader and pacesetter of the vast voluntary medical prepayment system, our efforts were soon supplemented by the private insurance industry, which today underwrites about as much medical care insurance as do the nation's Blue Shield Plans.

Now—in 1960—we face a new challenge in the proposal to utilize the Social Security system to underwrite medical care for its aged beneficiaries. There are many who fear that this would be only a preliminary step to the extension of medical care coverage through Social Security to the entire population.

How can medicine meet this new challenge? Why not look again to Blue Shield, medicine's own prepayment mechanism? Blue Shield today has earned a vote of confidence from more than 45 million citizens and it also enjoys substantial—though not uncritical—support from much of labor and industry.

Our local Blue Shield programs vary widely in scope of coverage, in the degree of assurance of full payment that they offer the patient, and in the adequacy of their payments to physicians. Some Plans are very good, while some others are scarcely worthy of public support or professional endorsement.

If we are to meet the challenge of the 60's and keep our patients and our profession free of political domination, we must make every one of our Blue Shield Plans as good as the best of them. If we fail to give all the people of America the very best medical prepayment program we can possibly offer them, they may look elsewhere for the answer to this challenge.

Whom Should the Doctor Protect?

Grand Rapids Press, October 10, 1960

Socialized medicine isn't the only question bothering the medical profession nowadays. Equally distressing for many of its members is how far a doctor may properly go in revealing what a patient may have told him. The issue is raised by the testimony of Dr. Clarence Schilt, a psychiatrist, in a hearing before the house committee on un-American affairs. Dr. Schilt treated Bernon F. Mitchell, one of the two national security agency code clerks who defected to Russia. In discussing the case, Dr. Schilt made certain disclosures concerning Mitchell's family, religious and sex problems. A number of his colleagues think he has betrayed his greatest trust.

This obviously involves matters of importance not only to physicians but to the nation. It has been argued—soundly we believe—that when Mitchell went over to the Soviets he abandoned whatever claim he might have had to protection of statements given his doctor in confidence. In this instance, too, Dr. Schilt revealed what he did because, in his words, "I believe the rights of the government far exceed the rights of individuals." By "government" he means all the people of the United States, who are endangered by Mitchell's

(Continued on Page 130)



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Whom Should the Doctor Protect?

(Continued from Page 128)

defection, and with this point of view it would be hard to quarrel.

The American Bar Association has made a fitting comment on this whole subject in noting that "the odd thing about the privilege (that of refusing to divulge information given doctors in confidence) is that it is usually invoked to protect from disclosure a bodily condition which has not been kept secret at all from friends and neighbors." In short, there are many occasions when invoking it means compelling courts and others to rely on nonauthoritative statements instead of expert opinion.

English courts are disinclined to respect such confidences, and so are many state courts in this country. Physicians deeply concerned about preserving the sanctity of the doctor-patient relationship understandably are against any compromise on this point. But as in so many other matters, we must trust to the courts and quasi-judicial bodies not to go beyond reasonable limits in demanding that doctors reveal what they may know about their patients. There can be no excuse for jeopardizing national security or effective law enforcement by insisting that all personal confidences received by doctors shall be protected no matter what.

Doctors Go Forward

Detroit News, October 6, 1960

The President's Program proposal of the Michigan State Medical Society to work toward increasing life expectancy in Michigan by five years is a progressive idea from an organization that frequently seemed committed to an absolute status quo.

Any suggestion that did not emanate from within the profession itself was immediately tagged as "socialized medicine" and a heresy in which an organized physician was forbidden to believe. The result was the alienation of many good friends of the profession and a steady down-grading of the status of the doctor in the public mind.

Dr. Kenneth H. Johnson, president-elect of the Michigan Society, spoke only the truth when he said that the plan presented physicians with an opportunity to present a united front at a time when social changes are challenging the profession.

"Only by justifying our existence as a profession, proving that we are worthy in a broad sense, can we hope to survive," he said.

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Doctors Go Forward

(Continued from Page 130)

view and if it prevails will restore organized medicine to the lofty plane on which the public in former times had placed it.

In the Fish Bowl

Oakland County Medical Society Bulletin, October 1960

It is well known that practitioners of medicine have been subjected to close scrutiny by the laity since the days of Hippocrates. An aura of mystery and sorcery blanketed us for many centuries and physicians were regarded with fearful awe or even the unreasoning hate reserved for those who are not understood.

Today, the constant barrage of material concerning medicine, which explodes from the instruments of mass media, finds eager ears and thirsty minds among the people. The cloud of mysticism is rapidly being dispelled by the cold light of scientific truth, and mass education is disseminating this truth with breathtaking speed.

Amid the present social upheaval, with clashing ideologies vying for men's minds and bodies, a calm, thoughtful approach to the solving of world problems is often supplanted by precipitant action. A current example of this has been the recent rash of legislative efforts in the field of medical care. We should neither be surprised nor unnerved by such action on the part of our elected officials as they are merely reacting to the rising tide of popular interest in this important field. We must not forget, however, that we can not legislate against all human frailties and that today's political promises are tomorrow's taxes.

In the light of both past and present experience, we must expect to live both our professional and our private lives with the same degree of privacy afforded the pet fish by his bowl. As is always the lot of a minority group, the whole are judged by the actions of a few. Every ostentatious act; every show of greed, selfishness or callous indifference; and every thoughtless, careless or indolent action are magnified in the eyes of the public and fan the smoldering fire of classical resentment against the members of our profession.

We must consider with care the impact of our utterances in both public and private upon the sensitive ears of the listeners. We must be acutely aware that we may differ in opinion with others with equal sincerity but must constantly test our motivations to avoid the materialistic approach characterized by those who use people and love things, rather than use things and love people.

The future of medical practice will surely be decided by the image which we individually and collectively present to the public. Let us make certain that the actions of a few do not jeopardize the future of the majority by bringing to bear the full force of our moral wrath and indignation against the Judas-like weakness in our own hearts.

DALE R. DREW, M.D.

Civil Defense

For those who expect their lives to be saved by a perfect Civil Defense plan or 100 per cent adherence to suggestions, it must be stated that their destiny depends on how close they are to, or away from, the spot where the bomb hits. The hopeful thing is that while everyone is a candidate to die, they are also a candidate to live, particularly if they will adopt a do-it-yourself attitude toward survival.—CHARLES S. STEVENSON, Kansas City businessman and Missouri civilian aide to the Secretary of the Army, in *The Kansas City Star*, June 22, 1960.

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Helps New Medical School

A three-year grant of $1,037,500 by the W. K. Kellogg Foundation will aid The University of Connecticut to establish a School of the Basic Medical Sciences in Hartford.

This school, which will encompass the first two years of the medical curriculum and envisages the transfer of the students to traditional four-year medical schools for their junior and senior years, is the second of its type to be supported by the Foundation which made a grant similar in purpose and sum to the University of New Mexico last May.

Within the United States there presently are eighty-six medical schools with four-year programs and three schools of the basic medical sciences with two-year programs.

* * *

CALHOUN COUNTY CLINIC DAY—The Calhoun County Medical Society and faculty members of the University of Michigan Medical School, and the Wayne State University College of Medicine recently presented an interesting Clinic Day at Battle Creek. The morning program with Leland P. Shipp, M.D., as Chairman, consisted of 30 minute discussions by A. C. Curtice, M.D., James L. Wilson, M.D., Richard J. Bing, M.D., and Carl E. Badgley, M.D.

S. B. Winslow, M.D., was chairman of the afternoon session which included on the program Reed M. Nesbit, M.D., Isadore M. Lampe, M.D., and W. S. Reveno, M.D., all professors at the two medical schools.

Next was a panel discussion on thyroid disease by R. L. Mustard, M.D., moderator, and the discussants: W. S. Reveno, M.D., William H. Beierwaltes, M.D., and Robert R. L. Berry, M.D.

In the evening after dinner the over 120 registrants were addressed by William N. Hubbard, M.D., Dean of the University of Michigan Medical School, and Gordon H. Scott, Ph.D., Dean of Wayne State University College of Medicine, with Russell Mustard, M.D., acting as toastmaster. John M. Sheldon, M.D., chairman of the Michigan University Postgraduate Program, and M.S.M.S. officers were in attendance.

* * *

GIVEN AWARD—Jean B. Rosenbaum, M.D., Detroit, recently received the Michigan Society of Neurology and Psychiatry's Research Award at the Society's annual meeting at the Wayne County Medical Society headquarters. The award was for original research into the significance of the sense of smell in man.

* * *

LEAVES STATE—John W. Towey, M.D., Powers, has left his practice in the Upper Peninsula to go to Wisconsin. Dr. Towey was honored several months ago with a testimonial dinner by the Menominee County Medical Society.



WINDSOR CLINIC—The Annual Essex County Surgical Clinic is scheduled for April 26-28 in the new Cleary Auditorium, Windsor.

Outstanding teachers on the program include Ian Aird, M.D., University of London, England, and Robert M. Zollinger, M.D., Ohio State University.

Accommodations for this event can be made in hotels both in Windsor and Detroit. Registration and program requests may be sent to Essex County Surgical Clinic, 301 Canada Building, Windsor, Ontario, Canada.

* * *

MILITARY SURGEONS—The 67th Annual Meeting of the Association of Military Surgeons of the United States was attended by 2,086 persons. Leroy E. Burney, M.D., The Surgeon General of the U. S. Public Health Service, Washington, will be president in 1961. The 68th Annual Meeting will be held at the Mayflower Hotel, Washington, D. C., November 6, 7, and 8, 1961.

* * *

HOXSEY INSTITUTE CLOSED—The Government has officially announced that the Hoxsey Cancer establishment is completely closed by a Federal Court order.

Commenting on the case, Commissioner Larrick said: "It is estimated that cancer patients have paid over $50,000,000 for this worthless treatment since its inception. The injunctive decrees culminate 10 years of almost continuous litigation in the Food and Drug Administration's efforts to curb this worthless nostrum."

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CARL V. WELLER LECTURE—Colonel James E. Ash, former Director of the Armed Forces Institute of Pathology, presented the fifth annual Carl V. Weller lecture to the Michigan Pathological Society at 5 p.m., December 10, in the Horace H. Rackham amphitheater in Ann Arbor. Dr. Ash spoke on "Neurogenic Tumors of the Upper Respiratory Tract."



Col. James E. Ash



F. K. Mostofi, M.D.

Preceding the Weller lecture was a slide seminar on "Lesions of the Genitourinary System," moderated by Dr. F. K. Mostofi of the Armed Forces Institute of Pathology. Dr. Mostofi is currently Secretary-Treasurer of the International Academy of Pathology. The slide seminar also was held in the Horace H. Rackham building at 2 p.m. It is part of the continuing program of post-graduate education for Michigan pathologists.

The Carl V. Weller lectures were first established in 1956 to honor the retiring chairman of the Department of Pathology of the School of Medicine of the University of Michigan. The late Dr. Weller was instrumental in the organization of the Michigan Pathological Society and served as its first president in 1932-33.

* * *

JOURNALS, EDITORS HONORED—The American Medical Writers Association at its 17th Annual Session in Chicago presented Awards of Distinguished Service to four medical journals. Honored were "THE NEW PHYSICIAN," published monthly by the Student American Medical Association, with Russell F. Standacher, the executive editor and business manager; *The Quarterly Bulletin of Northwestern University Medical School*, published quarterly; *Cancer Research*, published monthly, and *MD Medical Newsmagazine*, published monthly in New York.

The awards were presented by Dr. Austin Smith, President.

Fellowships were also given, including plaques "in recognition of high qualifications, personal and professional, and of established standing as a medical writer, journalist or publisher" to the following from Michigan—Russel Nelson DeJong, M.D., Ann Arbor; Sara Jane Houtz, Detroit; and Wilfrid Haughey, M.D., Battle Creek.

* * *

OFFERS TAPE—A special report on aftercare, tape recorded during the 116th annual meeting of the American Psychiatric Association, is available to the nation's psychiatrists and state mental hospitals by Smith, Kline & French Laboratories, 1500 Spring Garden Street, Philadelphia 1, Pa. This is the fourth tape on highlights of major psychiatric meetings prepared by the pharmaceutical firm. It was recorded by the Audio-Digest Foundation.

U-M CONFERENCE SOON—The Annual Conference in Ophthalmology will be held April 24, 25 and 26 at the Rackham Graduate School Building, Ann Arbor. The conference will be conducted by F. Bruce Fralick, M.D., and staff of the Ophthalmology Department. The following guest lecturers will participate: Robert W. Hollenhorst, M.D., Rochester, Minnesota; Charles E. Iliff, M.D., Baltimore, Maryland; S. D. McPherson, Jr., M.D., Durham, North Carolina, and Warren A. Wilson, M.D., Los Angeles. Further information may be obtained from the Department of Postgraduate Medicine, University Hospital, Ann Arbor.

* * *

MEDICAL TELEVISION SHOWS—The Michigan Health Council reports that the following topics were covered during November on the weekly Sunday morning program over WJBK-TV, Detroit: Nursing, Cerebral Palsy, Dentistry and Muscular Dystrophy.

* * *

WMA MEETING SET—The 15th annual conference of the World Medical Association will be held at Rio de Janeiro, Brazil, in September, 1961. Numerous trips are planned, including a 38-day cruise.

* * *

PRESENTS PAPER—A. D. Ruedemann, Jr., M.D., Detroit, recently presented a paper, "A Clinical Study of Alternating Hypertropia," at the annual scientific meeting of the Southern Medical Association Section on Ophthalmology and Otolaryngology, at St. Louis, Mo.

DISCUSSES CANCER—Harry M. Nelson, M.D., Detroit, gave addresses on "Detection of Cancer in the Well Person" and "Neoplasms of the Pelvis" at the Regional Meeting of the Academy of General Practice at Seattle, Washington, in which four northwestern states participated.

* * *

SPEAKS—Sidney Friedlaender, M.D., Detroit, recently appeared on two programs—"Panel on Repository Therapy" at the Midwest Forum on Allergy, Pittsburgh, and "Symposium on Parenteral Uses of Corticosteroids" at Ohio State University College of Medicine.

* * *

FELLOWSHIP DIRECTORY AVAILABLE—"Financial Assistance Available for Graduate Study in Medicine," just published by the Association of American Medical Colleges, can now be purchased from AAMC headquarters. The price of the book is $2.00.

* * *

NAMED RUSSEL LECTURER—Jerome W. Conn, M.D., Ann Arbor, was selected as a Henry Russel Lecturer, the highest honor The University of Michigan can give a faculty member. Dr. Conn will deliver the Russel Lecture next spring.

* * *

INCREASE RESEARCH AID—A total of $800,000 was spent on arthritis research during 1959 by the Arthritis and Rheumatism Foundation. This represents a rise of 40 per cent in a single year. Research money supports study of



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* * *

HEAR NEW YORK MAN—Alexander Gralnick, M.D., High Point Hospital, Port Chester, New York, was the sixth speaker of the series of scientific programs held under the auspices of The Haven Sanitarium, Rochester. Dr. Gralnick spoke on "Family Psychotherapy: General and Specific Considerations," at the Statler-Hilton Hotel, December 3.

* * *

HONORED BY COMMUNITY—John R. Rodger, M.D., of Bellaire, was the honored guest, with his wife, at a testimonial dinner and program recently at Bellaire. The event recognized 25 years of medical service to the community, where Doctor Rodger is very active in civic affairs. The Michigan State Medical Society was proud to be one of the many organizations which paid tribute to the Rodgers during the program. Dr. Rodger has been the chairman of the MSMS Committee on Study of Prevention of Highway Accidents and has been active, too, on AMA work in the area of traffic safety.



* * *

JOINS ACOG—Robert A. Kimbrough, Jr., M.D., Philadelphia, has assumed duties as the first medical director of The American College of Obstetricians and Gynecologists, Chicago. He will coordinate activities which deal with medical problems and policies. Doctor Kimbrough was a consultant in gynecology and obstetrics to the Surgeon General of the United States Army.

* * *

RECEIVE GRANTS—Research grants totaling over $523,000 have been made to 40 scientists so far in 1960 by the Tobacco Industry Research Committee, including two in Michigan: (1) Richard J. Bing, M.D., Detroit, on "The Effect of Smoking on Coronary Blood Flow in Patients with Arteriosclerotic Heart Disease," and "The Effect of Nicotine on Storage of Amines in Heart Muscle," and (2) Richard U. Byerrum, Ph.D., East Lansing, for "Biosynthesis of the Pyridine Ring of Nicotine."

* * *

HOSPITAL CITED—The University of Michigan Hospital has won recognition from the American Hospital Association in the fields of public relations and business management.

Roger B. Nelson, M.D., associate director of the hospital, accepted the award during the annual convention of the Association in San Francisco. Recognition was given to the hospital for its public relations program during the past year. Judges considered patient relations, employee relations, and services to the general public and community.

* * *

ELECTED—Paul J. Connerly, M.D., Detroit, was elected a governor of the American College of Gastroenterology at the annual meeting in Philadelphia, Pa. The next annual meeting will be held in Cleveland in October, 1961.

APPOINTED—Richard S. McCaughey, M.D., Detroit, is the new medical director of the Yates Memorial Clinic, a cancer detection clinic sponsored by the Michigan Cancer Foundation in Detroit. Dr. McCaughey replaces Gerald S. Wilson, M.D., who retired after seven years as Yates director to devote his time to private practice.

* * *

WINS RECOGNITION—William Martel, M.D., Ann Arbor, has received the silver medal of the American Roentgen Ray Society for his scientific exhibit on the effects of rheumatic diseases in vertebrae of the neck. He was honored for his work with x-ray findings in patients afflicted with the disorder.

* * *

RHODE ISLAND EDITOR—The *Rhode Island Medical Journal* reports with sorrow the death, on September 17, 1960, of John E. Donley, M.D., Editor for many years, past president and recipient of the Charles Value Chapin Award. Seabert J. Goldowsky, M.D., Providence, is the new editor.

* * *

OPHTHALMOLOGY FELLOWSHIPS—Six additional Fellowships for Residents in Ophthalmology, to be awarded July 1, 1961, have been announced by the Guild of Prescription Opticians of America. Each Fellowship is for a total of $1,800, payable in monthly stipends over the period of a three-year Residency.

Application forms and covering information are available by writing to FELLOWSHIPS, Guild of Prescription Opticians of America, Inc., 110 East 23rd Street, New York 10, N. Y.



PRIZE WINNER—The exhibit of the American Cancer Society at the Michigan State Fair was awarded the first-prize trophy for small exhibits in health and science. Volunteers distributed informational booklets from the exhibit.

* * *

PATHOLOGICAL CONFERENCE — A combined Meeting of the Great Lakes Region of the College of American Pathologists and the Michigan Pathological Society, will be held February 11, 1961, at the Henry Ford Hospital, Auditorium, Detroit.

The morning session 9:30 a.m. to 12:30 p.m., will be devoted to a "Workshop on Instrumentation and Automation" by George Z. Williams, M.D., Chief, Clinical Pathology, and William Sunderman, Jr., M.D., Clinical Chemist, Depart-

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ment of Health, Education and Welfare, Public Health Department, Bethesda, Maryland.

Robert Horn, M.D., Director of Laboratories, Henry Ford Hospital, will be the luncheon speaker. His topic will be: "Socio-economic Impact of Automation on the Practice of Pathology."

A Slide Seminar on "Pediatric Tumors" will be presented from 2:30 to 5:30 p.m. by James B. Arey, M.D., Professor of Pediatric Pathology, Temple University and Pathologist for St. Christopher's Hospital for Children, Philadelphia, Pennsylvania.

Reservations for the luncheon, which *must* be made in advance, should be made through: Dr. Robert Horn, Director of Laboratories, Henry Ford Hospital, Detroit 2, Michigan.

* * *

HONORED—Vida G. Brekke, M.D., of Highland Park, is the new president of the Michigan Pathological Society for 1961. She is the first woman to lead this society. Doctor Brekke was graduated from the Wayne State University College of Medicine and now is pathologist and director of laboratories at the Highland Park General Hospital. She is a member of the advisory council of the American Society of Clinical Pathologists.



* * *

HOST MEDICAL STUDENTS—About 200 pre-medical students and their advisers from seven Michigan colleges and universities were guests of The University of Michigan Medical Center for a recent "Medical Careers Program."

The program included the "clinical presentation" of a patient, tours of the Medical Center and research laboratories, a "live" color TV program on University Hospital's closed circuit system, and a talk on "Medicine As A Career" by Albert C. Furstenberg, M.D., dean-emeritus of the U-M Medical School.

Students and counsellors attended from Albion College, Calvin College, Hope College, Kalamazoo College, Michigan State University and Western Michigan University and the University of Michigan.

The event was the first of its kind to be held by the U-M Medical School.

* * *

AVAILABLE—A young x-ray technician, recently released from military service, is seeking a position in a physician's office, clinic or hospital. Training was received in the Air Force. For information, write P.O. Box 539, Lansing.

* * *

COMING MEETINGS—American College of Physicians Post Graduate course No. 4, January 9-13, 1961, Washington University School of Medicine, Seattle, Washington.

Fifteenth Annual Symposium on Fundamental Cancer Research, sponsored by the University of Texas M.D. Anderson Hospital and Tumor Institute, February 23-25, 1961, M. D. Anderson Hospital Auditorium, Houston, Texas. For further information, write the Publications Department, The University of Texas M. D. Anderson Hospital and Tumor Institute, Texas Medical Center, Houston 25, Texas.

American College of Allergists Graduate Instructional Course and Seventeenth Annual Congress, March 12-17, 1961, Statler Hilton, Dallas, Texas. For information, write John D. Gillaspie, M.D., Treasurer, 2141 14th Street, Boulder, Colorado.

Fourteenth Annual Spring meeting of the West Virginia Academy of Ophthalmology and Otolaryngology, April 6-8, 1961, Greenbrier Hotel, White Sulphur Springs, West Virginia. For additional information, contact the secretary, Dr. Worthy W. McKinney, 109 East Main Street, Beckley, West Virginia.

Annual Clinical Conference of the Chicago Ophthalmological Society, May 19-20, 1961, Drake Hotel, Chicago, Illinois. For information, write the registrar, Mrs. Mary E. Ryan, 1150 North Lorel Avenue, Chicago 51, Illinois.

American Medical Association, Annual Meeting, June 26-30, New York City, N. Y.

Fourth International Congress of Allergology, October 15-20, 1961, Hotel Commodore, New York City. For information, write William B. Sherman, M.D., 60 E. 58th Street, New York 22, New York.

COMMUNICATIONS

15 November 1960

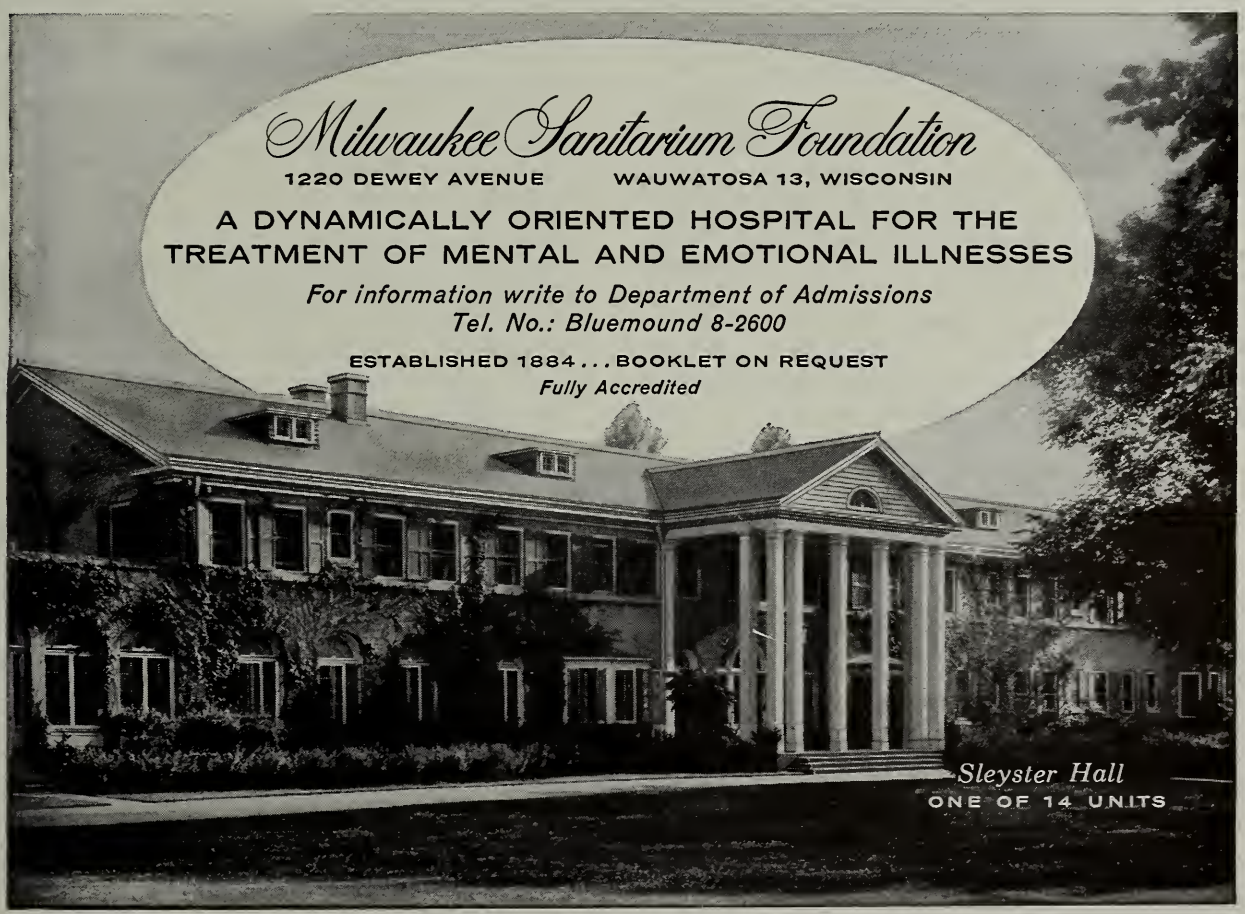
Dear Doctor Haughey:

In the October 1960 issue of *The Journal of the Michigan State Medical Society* is a very nice review of the second neurosurgical volume in the series dealing with the history of the U. S. Army Medical Department in World War II.

I hope you will tell J. C. G. for me that I am most appreciative of his kind words about this book, and I am sure the authors and editors will be equally gratified by them. I was particularly happy to have him emphasize its peacetime value.

My thanks, again, go to you for giving space in your journal for the reviews of these volumes. A great many of them are now being reprinted, and for their popularity we can thank editors such as yourself. Should another war come, the widespread knowledge of the facts in these volumes will save us from much of the lost time and the many errors that were made because there was no such knowledge of the mine of information contained in the history of the Army Medical Department in World War I.

Sincerely yours,
John Boyd Coates, Jr.
Colonel, Medical Corps
Editor-in-Chief, The Historical Unit
United States Army Medical Service
Washington 12, D. C.



IN MEMORIAM

DONALD A. BAILEY, M.D., sixty-six, retired Highland Park physician, died November 23, 1960.

Doctor Bailey was born in Lansing and lived in Detroit sixty years. He practiced in Highland Park for many years before retiring in 1952.

He was a graduate of the Detroit College of Medicine and was on the staff of Highland Park General Hospital.

ISAAC S. GELLERT, M.D., eighty-one, Detroit obstetrician and gynecologist for fifty-eight years, died November 4, 1960.

Born in New York City, Doctor Gellert was a 1902 graduate of the old Detroit College of Medicine (now Wayne State University). He interned at old St. Mary's Hospital (now Detroit Memorial Hospital) and then took a residency at Lying In Hospital, New York City. He took post graduate work in his specialty in Paris, France.

Doctor Gellert served in the U. S. Navy during the Spanish American War, and during World War I he served as a captain in the Army Medical Corps. He was a member of Pingree Post, United Spanish War Veterans.

Among his many medical affiliations, he was a member of Nu Sigma Nu medical fraternity.

C. D. KLAUS, M.D., fifty-seven, died October 22, 1960.

Doctor Klaus for three years had been acting chief of the physical medicine and rehabilitation service of the Iron Mountain Veterans Administration Hospital, and a staff physician there.

A native of Green Bay, Wis., he was graduated from Northwestern University and Loyola University School of Medicine in 1931. He practiced medicine in Grand Rapids for twenty years before accepting the appointment to the VA facility staff. In conjunction with his private practice, he also served as examining physician for the VA Regional Office at Grand Rapids from 1946 to 1955.

He was a member of the Veterans of Foreign Wars Post and Furniture City Post 208, American Legion of Grand Rapids, the Chippewa Club of Iron Mountain and the Phi Sigma Chapter of the Sigma Chi Fraternity.

CHRISTOPHER G. PARNALL, M.D., eighty, died November 6, 1960, in the University of Michigan Hospital he had helped design some forty years ago.

A 1904 graduate of the U-M Medical School, Doctor Parnall served as director of the "old" University Hospital from 1918-1924, at the time when the present 1,000-bed hospital was being planned.

He was born June 2, 1880 at Rockland, Michigan and received his bachelor of arts degree at the University of Michigan in 1902. Doctor Parnall served as first assistant in obstetrics and gynecology at the U-M from 1904-1906, and was in practice in Jackson from 1906-15.

He had a national reputation for planning of hospitals and medical schools. He did the functional planning for the University of Iowa Medical School and planned hospitals for the University of Texas, Baylor University, the Harrisburg Polyclinic, the Eli Lilly Laboratories, Indianapolis, and the city and county hospitals of Houston, Texas.

From 1924 until he retired in 1945, Doctor Parnall served as director of the Rochester Hospital, Rochester, N. Y.

On September 22, 1958, Doctor Parnall was honored at the annual U-M Medical Convocation for his vision in laying the grounds for the University's modern Medical Center and for his pioneering concepts in hospital administration. He was instrumental in bringing Foote Hospital into being and served as its first superintendent. He aided in the planning of the present Washtenaw County Hospital while a member of the Board of Supervisors in 1922-23, representing the former Sixth Ward.

Doctor Parnall was an organizer of the Jackson Rotary Club.

Doctor Parnall received the Michigan State Medical Society's Fifty-Year Award in 1955.

JOSEPH L. RADAI, M.D., thirty-seven, divisional medical director of Saginaw Steering Gear Division, General Motors Corporation, died October 28, 1960.

A graduate of the University of Pennsylvania Medical School in 1952, he became a member of the Milwaukee County General Hospital and Industrial Clinic, then joined

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the medical staff of GM Technical Center at Warren. He assumed his post at Steering Gear in September of 1959.

Doctor Radai served as a pursuit pilot in the Army Air Forces from September, 1942, to April, 1946.

CHARLES A. REINBOLT, M.D., eighty-five, retired Detroit-area physician, died October 30, 1960.

Born in Napoleon, Ohio, he had lived sixty-five years in the Detroit area.

He was one of the founders of Highland Park General Hospital and for many years was its chief of staff.

He was a Mason and a charter member of the Red Run Golf Club.

ARTHUR M. SHAEFFER, M.D., sixty-seven, Jackson physician and surgeon, died October 19, 1960.

Doctor Shaeffer, whose specialty was internal medicine and the heart, was born in Amanda, Ohio. He was graduated from Amanda High School and Ohio State University. He was the first intern in the then new Foote Hospital in 1918, served with the Army medical corps in 1918-1919 and returned to private practice in Jackson after the war.

He was on the staff of both Mercy Foote hospitals. He was a past president of the Jackson County Medical Society, and in addition to his many professional affiliations, was a life member of the Jackson Shrine and Jackson lodge No. 17 F & A M, a member of the Kiwanis Club and the Country Club of Jackson.

WALTER K. SLACK, M.D., sixty-one, for more than thirty years a Saginaw eye-ear-nose and throat specialist, died November 13, 1960.

A native of Saginaw, Doctor Slack was graduated from the University of Virginia Medical School and interned at University Hospital, Ann Arbor, before becoming a resident at Presbyterian Eye and Ear Hospital, Baltimore.

Doctor Slack was a member of the staff at St. Mary's Hospital, serving for several years as its chief.

He was an infantry private in World War I and was a naval commander in World War II, serving in the Pacific.

He was a 33rd-degree Mason and a member of the First Congregational Church in Saginaw.

EDWARD T. TORWICK, M.D., fifty-eight, practicing Jackson physician for sixteen years, died October 25, 1960.

A native of Minnesota, Doctor Torwick received his bachelor of science degree at South Dakota State College and taught and coached in the Hetland, S. D., high school. He was superintendent of schools at Fort Pierre, S. D. He left teaching to study medicine at the University of South Dakota and earned his medical degree at Rush Medical College at Chicago. Doctor Torwick began his practice at Volga, S. D., in 1933 and came to Jackson in 1944.

He was a member of the Phi Chi national medical fraternity, the Lutheran church and the Lutheran brotherhood.

Michigan Authors

O. J. King, M.D., and **W. W. Glas, M.D.,** Eloise, "Complications of Tracheostomy," *Rocky Mountain Medical Journal*, August, 1960.

Kenneth R. Magee, M.D., and **Russell N. DeJong, M.D.,** Ann Arbor, "Paralytic Brachial Neuritis," *Journal American Medical Association*, November 5, 1960.

J. W. Rebuck, M.D., Jeanne M. Riddle, S. A. Johnson, Ph. D., R. W. Monto, M.D., and **Ruth M. Sturrock,** Detroit, "Contributions of Electron Microscopy to the Study of Platelets," *Henry Ford Hospital Medical Bulletin*, September, 1960.

Boy Frame, M.D., and **Gordon Manson, M.D.,** Detroit, "Refactory Rickets and Osteomalacia," *Henry Ford Hospital Medical Bulletin*, September, 1960.

John F. Coleman, M.D., Robert Ziegler, M.D., and **Edward Green, M.D.,** Detroit, "Pediatric Cardiac Catheterization Analgesia or Anesthesia," *Henry Ford Hospital Medical Bulletin*, September, 1960.

John N. Canton, M.D., and **C. Paul Hodgkinson, M.D.,** Detroit, "Granulosa and Theca Call Tumors of the Ovary," *Henry Ford Hospital Medical Bulletin*, September, 1960.

Richmond W. Smith, Jr., M.D., and **Raymond C. Mellinger, M.D.,** Detroit, "Some Fundamentals of Gonadal Development and Function," *Henry Ford Hospital Medical Bulletin*, September, 1960.

William G. McEvitt, M.D., Detroit, "The Use of Shoulder Flaps in Facial Reconstruction," *The Journal of the International College of Surgeons*, November, 1960.

Donald C. Durman, M.D., Saginaw, "Trauma in the Causation and Aggravation of Arthritis," *The Journal of the International College of Surgeons*, November, 1960.

Andrew F. Caughey, Jr., M.D., Detroit, "Rh erythroblastosis and ABO incompatibility," *American Journal of Obstetrics and Gynecology*, September, 1960.

Morris J. Mintz, M.D., and **Max W. Mattes, M.D.,** Detroit, "Detection of Foreign Bodies in the Anterior Chamber of the Bulbus Oculi," *Radiology*, October, 1960.

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H. M. Nelson, M.D., and **S. Guindi, M.D.,** Detroit, "Ectopic Pregnancy," *Postgraduate Medicine*, October, 1960.

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J. Reimer Wolter, M.D., Ann Arbor, "Regenerative Potentialities of the Centrifugal Fibers of the Human Optic Nerve," *Archives of Ophthalmology*, November, 1960.

Harry M. Nelson, M.D., Esther H. Dale, M.D., and **Gerald S. Wilson, M.D.,** Detroit, "Management of the Patient with the Positive Vaginal Cell Examination," *Bulletin of Cancer Progress*, July-August, 1960.

FACTORS DETERMINING SKIN-DRUG-VEHICLE RELATIONSHIP

This paper presents a review of recent finding in the fields of cutaneous physiology and pharmacology that relate to topical therapy, discussed primarily from a functional standpoint. The factors affecting the equilibrium between the normal epidermis and various types of vehicles were considered, as well as the effect of this physico-dynamic relationship on drug diffusion and penetration. The condition of the stratum corneum was found to be of prime importance in selection of the therapeutic modality. Certain problems in this field of investigation were defined and approaches to these suggested.—J. B. SHELMIRE, JR., M.D., *Archives of Dermatology*, July, 1960.

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Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

THE LIST METHOD OF PSYCHOTHERAPY. By Elizabeth Sher, Eleanor Messing, Theodora Hirschhorn, Enie Post, Annette Davis, and Arthur Messing. With an introduction by Jacob S. List. New York: Philosophical Library, 1960. Price, $7.50.

This book is a collection of essays by six different people, each of whom describes some different element in the compound. I believe that this book, since it actually attacks certain positions held by thoughtful men of honor and prestige, is likely to be received in many different ways, from anger to dismay, and from enthusiasm to amusement.

The book actually is written for everybody, for it touches everybody with either approval or disapproval. The psychoanalytic M.D. (member of the American) and the Ph.D. psychologist (member of the American Psychologic) seem to be singled out for the heaviest opprobrium. I suppose that the authors in criticizing psychonanalysis and psychology emphasize the kind of mentality and operating procedure of the worst members and least competent people in both fields, in order to elicit contrast.

There is much here for the general physician; he will be assisted with new ideas, concepts which will help him. Simultaneously, however, there are many excellent family doctors and other specialists who practice the List method without ever having heard of it.

This book is recommended as a non-offensive and kindly guide to counselling to any audience not committed previously to some orthodox position.

W.R.S.

CAREER FINDER. A Scientific Slide Rule designed to help you (1) know your own qualifications and (2) know the kind of work you are best fitted to do. By Keith Van Allyn. Los Angeles 38, California: Personnel Research, Inc., 1960.

This Career Finder is a very clever streamlined testing program which can be used individually or in groups to reveal qualifications for success in a given occupation. It is a suggested replacement for the traditional application form and personal interview used in most job selections. This covers much the same ground as the detailed preference tests given in the schools today, showing aptitudes in the following areas: arts, biology, computation, literary, physical, and social capability, and technology. This would seem to be a more scientific way of directing the employee to a position where he will be most valuable in his work, and which will be more likely to satisfy him as well as his employer.

ADVENTURE TO MOTHERHOOD. The picture story of pregnancy and childbirth. By J. Allen Offen, M.D., Assistant Professor of Obstetrics and Gynecology, University of Miami School of Medicine; Attending Obstetrician and Gynecologist, Jackson Memorial Hospital. Miami 52, Florida: Audio Visual Education Company of America, Inc., 1960. Price, $2.95.

A concise pictorial book, the photographs depict a patient from her first visit to her doctor through her prenatal visits and hospitalization. Diagrams of fetal development and labor are explained. Abnormalities are included in separate leaflets to be given to the patient at the discretion of the doctor.

This is an excellent book for the intelligent mother-to-be, but should not be given to a highly emotional or nervous person in view of the detailed pictures of the delivery.

J.R.P.

THE QUESTION OF FERTILITY. By Georges Valensin, M.D. Translated from the French by Leah Suchodolski. Garden City, New York: Doubleday & Company, Inc., 1960. Price, $4.50.

This is an authoritative and enlightening book which provides interesting reading for all on the subject of fertility, but is of the greatest importance to the general practitioner. The author discusses three individual factors in fertility, namely—the woman, the man, and the couple. The question of fertility is treated from the standpoint of environment, heredity, food, clothing, medications, emotional, mental and socio-economic conditions.

The question of artificial insemination, both in the past and the present, together with its religious and legal problems is discussed in detail. The preparation for artificial insemination and the question of the donor are excellently treated. The author incorporates experimental work as well as practical applications in both the field of fertility and artificial insemination.

J.R.P.

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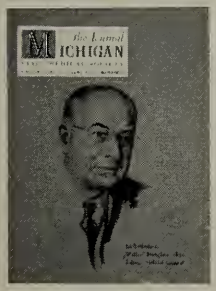
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THE COVER

The fine portrait of Wilfrid Haughey, M.D., Editor of THE JOURNAL MSMS, was made by John S. Coppin, of Detroit, and was made available by the Michigan Medical Service. The cover art and this tribute to Dr. Haughey will be a surprise to him!

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Kestler reports in J.A.M.A. (April 30, 1960) that conventionally treated low-back syndrome patients required an average of 41 days for full recovery (range: 3 to 90 days). The addition of Soma therapy in this comparative investigation reduced the average to 11.5 days (range: 2 to 21 days). With Soma, patients averaged full recovery 30 days sooner.

President's Page

THANKS, DR. HAUGHEY!



This month I'd like to add my plaudits to all Medical Writers and especially to MSMS Editor Wilfrid Haughey, M.D.

Some months ago, when the idea of dedicating this February JOURNAL was developed, The Council and its Publication Committee were enthusiastic about devoting this number to medical writers. Then, when the medical writers themselves began to work out the details, they quickly seized the opportunity to recognize the outstanding service performed by Editor Haughey.

And lest anyone be accused of immodesty, let me assure you that the cover design and the excellent guest editorial by J. P. Gray, M.D., were kept a deep, dark secret from Doctor Haughey.

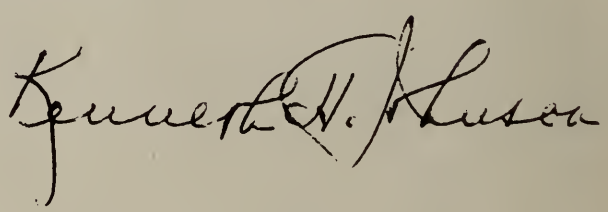
Medical writers with their unique ability to communicate through the written word perform an extremely valuable service for the medical profession.

Gentlemen, we salute you all!

But, if I may, I would like to single out Doctor Haughey, the Dean of Michigan Medical Writers, for special praise. Doctor Haughey's talents and editing ability have been recognized many times over the years. Yet, to me, it seems that not enough has been said about the devotion of this man to his avocation. Each month, Doctor Haughey is confronted with the huge task of selecting scientific material, writing timely and informative editorials, and coordinating the entire Journal from thought to print.

The hours of proof-reading, correcting, and making countless decisions are mainly a thankless task, but there are some rewards. First, the respect and admiration of MSMS for a job well done brings satisfaction; and certainly, all of us take pride in the fact that the MSMS JOURNAL was one of three state medical journals singled out for honors by the 1959 American Medical Association Conference of Journal Editors.

The improvements in typography, layout and design —the "new look" of JMSMS—is a measure of the Editor who is not content with status quo. I am sure the future holds even greater improvements in all departments, so that Michigan doctors will have the finest editorial voice among state medical publications—thanks to Medical Writer Haughey!



Resolution Institutes MSMS Presidents Program

Members Urged to Read House of Delegates Resolution, Printed Here in Full



MSMS members will be invited in the coming months to participate in the new five-year Presidents Program, which was instituted by the 1960 MSMS House of Delegates. The five-year program will lead up to the Centennial Celebration by the State Medical Society in 1965.

At the House of Delegates, Kenneth H. Johnson, M.D., MSMS President, pointed out that the plan offers Michigan doctors of medicine an opportunity to present a united front at a time when social changes are challenging the profession.

Resolution No. 25, which institutes the Program, follows in full:

WHEREAS, the challenge of today to the medical profession is to revitalize the unique power of the individual doctor to serve the whole person in sickness and in health, and

WHEREAS, to gain maximum benefit from the monumental gains of modern medical research it is necessary that the research findings be applied at the earliest opportunity to the maximum number of persons who could benefit by these new drugs, treatments, techniques or concepts of medical and health care, and

WHEREAS, the medical profession wishes to join with those segments of the public which are primarily concerned with health (as well as with all persons or groups who can make effective contributions to the general public health) as partners in a single, well-defined health program, and

WHEREAS, the Michigan State Medical Society, which has pointed with pride over the past 95 years to separate, individual "firsts" in medically-oriented activity, can now evidence the same willingness to serve the public interest by offering its leadership in a single, well-conceived and executed, integrated program, therefore be it

RESOLVED: That a five-year project be inaugurated by the Michigan State Medical Society specifically designed to utilize to the fullest extent:

A. The capabilities and knowledge of its individual members as leaders,

B. The facilities of its new headquarters as a "Campaign Control Center," and

C. Its staff and resources as communicating and coordinating services, toward the end of expediting plans which will hope to

1. result in an increase of 5 years in the general life expectancy of the people of Michigan, said increase to be attempted over the period of time beginning in September 1960 and concluding in September 1965 (the 100th anniversary of the Michigan State Medical Society), and

2. increase the potential productivity and usefulness of additional years of life; and be it further

RESOLVED: That to accomplish this goal The Council of the Michigan State Medical Society be empowered and urged to:

A. Seek the advice, aid and assistance of all members of the Michigan State Medical Society, as well as all related scientists, and the enthusiastic support of its county and district medical societies,

B. Support all reasonable efforts to place the latest developments of research into the armamentarium of the doctors of medicine of Michigan at the earliest possible date,

C. Request the assistance of, and coordinate its work and recommendations with, those qualified voluntary and governmental agencies to gain a maximum amount of progress toward the goal with a minimum of duplication of effort; and be it further

RESOLVED: That this effort be carried out at the top level of organizational work and to that end this project be promoted by each succeeding President of the Michigan State Medical Society during the next five years who will work in conjunction with the titular heads of all other pertinent organizations; and be it further

RESOLVED: That this project be known as the Presidents Program.

Mrs. Urmston Dies

Mrs. Louise T. Urmston, widow of the late Paul R. Urmston, M.D., died at her home at Bay City in early December. Her husband, Doctor Urmston, who died August 24, 1960, was president of the Michigan State Medical Society in 1940.

Mrs. Urmston had spent most of her life in Bay City where Doctor Urmston practiced otolaryngology for many years.

MCI to Stress Practical Applications

Speakers at the 1961 Michigan Clinical Institute will give special emphasis to the practical application of new medical advances, reports General Chairman Milton A. Darling, M.D., of Detroit.

The total program, he said, was planned to help the practicing physician in his daily work.

The refresher course will begin Wednesday morning and end Friday noon, March 8-10, at the Sheraton-Cadillac Hotel, Detroit.

The opening session on Wednesday will feature scientific papers on surgery. Wednesday afternoon will be devoted to trauma. "The Use and Abuse of Hypnosis" will be discussed by a panel of eminent men on Wednesday evening. Thursday morning will feature speakers on heart and rheumatic fever and the program Thursday afternoon will stress internal medicine and cancer. There will be an evening meeting on Thursday, emphasizing in particular the care of older people in nursing homes and homes for the elderly. Friday morning will report new advances in obstetrics and gynecology.

SOMETHING NEW—EIGHT DISCUSSION GROUPS. These instructional courses on topics of practical value must be limited in attendance to thirty M.D.s each, due to the facilities available in the hotel.

For your convenience in indicating which Discussion Group you wish to attend, reservation blank follows. Admission tickets will be mailed to those registering, on a "first come, first served" basis.

Reservation Blank

"DISCUSSION GROUPS" 1961 MICHIGAN CLINICAL INSTITUTE

Please select the one "Discussion Group" in which you would like to participate each day:

WEDNESDAY, MARCH 8, 1961, 8:00-9:00 a.m.:

1. *"Chemotherapy in Malignant Disease"*
☐ LEADER: George S. Fisher, M.D., Detroit
PANELISTS: Michael J. Brennan, M.D., Detroit
Alvin Watne, M.D., Buffalo, New York
2. *"X-Ray Diagnosis in Surgical Practice"*
☐ LEADER: Steven J. Figiel, M.D., Detroit
PANELISTS: Fred J. Hodges, M.D., Ann Arbor
Elmer F. Wahby, M.D., Grand Rapids
3. *"Unusual Fractures"*
☐ LEADER: Herbert D. Pedersen, M.D., Dearborn
PANELISTS: Robert W. Bailey, M.D., Ann Arbor
J. Otto Lottes, M.D., St. Louis, Missouri

THURSDAY, MARCH 9, 1961, 8:00-9:00 a.m.:

1. *"Respository Antigens: Preparation, Demonstration, and Administration"*
☐ LEADER: Fred M. Davenport, M.D., Ann Arbor
PANELISTS: Peter P. Barlow, M.D., Ann Arbor
Sidney Friedlaender, M.D., Detroit
2. *"Anemia"*
☐ LEADER: Raymond W. Monto, M.D., Detroit
PANELISTS: Freeman M. Wilner, M.D., Detroit
Chris J. D. Zarafonetis, M.D., Philadelphia, Pennsylvania
3. *"Selection of Patients for Cardiac Surgery"*
☐ LEADER: Prescott Jordan, M.D., Detroit
PANELISTS: Charles P. Bailey, M.D., New York City
Franklin D. Johnston, M.D., Ann Arbor
Richard R. Rasmussen, M.D., Grand Rapids

FRIDAY, MARCH 10, 1961, 8:00-9:00 a.m.:

1. *"Newer Drugs in the Treatment of Pregnancy Toxemia"*
☐ LEADER: Charles S. Stevenson, M.D., Detroit
PANELISTS: David N. Danforth, M.D., Evanston, Illinois
Arthur G. Seski, M.D., Detroit
2. *"Serious Complications of Pregnancy"*
☐ LEADER: Francis A. Jones, M.D., Lansing
PANELISTS: Charles A. Behney, M.D., Lansing
Laurel S. Eno, M.D., Detroit
Edward C. Mann, M.D., New York City

Note: *Members may submit in writing three weeks before the MCI, through Chairman of the Program Committee, John W. Sigler, M.D., c/o P.O. Box 539, Lansing 3, Michigan, questions concerning any phase of the subjects listed above. Moderators and Panelists will answer those questions which they feel are applicable to the subject under discussion, and will answer as many other questions as time permits.*

Signed:

Address:

City:

Return to:
Chairman John W. Sigler, M.D.
P.O. Box 539
Lansing 3, Michigan

(Turn to Page 160)



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Other Meetings During MCI

TUESDAY, MARCH 7, 1961

Michigan Chapter, American College of Surgeons—all day meeting beginning at 9:00 a.m. in the English Room and followed by 6:00 p.m. reception and dinner in the Book-Casino, Sheraton-Cadillac Hotel, Detroit.

Michigan Chapter, American Academy of Pediatrics—all day meeting beginning at 9:30 a.m. in the Children's Hospital followed by 6:00 p.m. social hour and dinner in the English Room, Sheraton-Cadillac Hotel, Detroit.

Tuesday, March 7, 1961

Morning Session—9:30 a.m. to 12:00 M

Moderator: *Robert M. Heavenrich, M.D.*, Chairman, Michigan Chapter AAP

A.M.

9:30 Registration

10:00 "The Nephrotic Syndrome in an Infant"—*B. Khodadadeh, M.D.* and *Edgar Martmer, M.D.*, Harper Hospital

10:20 (To be announced), Receiving Hospital

10:40 "de Toni Fanconi Syndrome"—*Jay Bernstein, M.D.* and *Ruben Meyer, M.D.*, Children's Hospital, Detroit

11:00 "Salicylate Intoxication"—*Donald Mason, M.D.* and *Arthur Tuuri, M.D.*, Hurley Hospital

11:20 "Peritoneal Dialysis"—*Emily Magimity, M.D.* and *Paul Woolley, M.D.*, Children's Hospital, Detroit

11:40 "Protein Requirements of Infants and Children"—*John Johnston, M.D., Gordon Manson, M.D., John Maroney, M.D., James Sweeney* and *Richard Brown, M.D.*, Henry Ford Hospital, Detroit

Luncheon—12:15 p.m. to 1:45 p.m.
Children's Hospital, Detroit

Afternoon Session—2:00 p.m. to 5:00 p.m.

Moderator: *Ruben Meyer, M.D.*, Alternate Chairman, Michigan Chapter AAP

P.M.

2:00 "Leukocyte Alkaline Phosphatase"—*Beverly Jewell, M.D.* and *James Wilson, M.D.*, University Hospital, Ann Arbor

2:20 "Stenosis of the Left Lower Lobe Bronchus, Chronic Infection, Growth Failure"—*Ronald Hoesksema, M.D.* and *Donald Waterman, M.D.*, Butterworth Hospital, Grand Rapids

2:40 "Coronary Rupture in a Child"—*Rudolph M. Jarvi, M.D.*, Saginaw General Hospital, Saginaw

3:00 "Hospital Pediatric Services in Michigan"—*Eugene Crawley, M.D.*, Director Child Health Services, Maternal and Child Health Section, State Health Department, Lansing

3:20 "Acute Hemocytic Anemia with Altafur Therapy"—*Joseph Grayson, M.D.* and *Julius Rutzky, M.D.*, St. Joseph's Hospital, Pontiac

4:00 (To be announced)—*Wolf Zuelzer, M.D.*, Children's Hospital

Evening Social Hour and Dinner—6:00 p.m.

P.M.

6:00 Social Hour—Sheraton-Cadillac Hotel, English Room (registration for Michigan Clinical Institute)

7:00 Dinner

8:30 "Trends in Immunizations"—*James Wilson*, Professor of Pediatrics, University of Michigan, Ann Arbor

Michigan Epilepsy Center and Association—5:30 p.m. reception-dinner-meeting in the Sheraton Room of the Sheraton-Cadillac Hotel, Detroit. Speaker is John Stirling Meyer, M.D., Detroit, Professor and Chairman, Department of Neurology, Wayne State University College of Medicine. Doctor Meyer will talk on "Cerebral Metabolism During Seizures and Post-Epileptic Paralysis." For dinner reservations, contact the Michigan Epilepsy Center and Association, 10 Peterboro, Detroit 1, FA 1-0105.

Michigan Diabetes Association—2:00 p.m. meeting followed by reception and dinner—all in the East and West Rooms of the Sheraton-Cadillac Hotel, Detroit.

Tuesday, March 7, 1961

Chairman: Ralph L. Fitts, M.D., Grand Rapids Chairman, Clinical Society

P.M.

2:00 "Methods of Detection of Diabetes Mellitus"—*John B. Bryan, M.D.*, Detroit

2:20 "Importance of Early Detection of the Diabetic State"—*Stefan S. Fajans, M.D.*, Ann Arbor

2:40 "Necessity of Careful Dietary Management of Diabetes"—*Robert D. Johnson, M.D.*, Ann Arbor

3:00 "Insulin Therapy—Mixtures (Lente) and in Combination with DBI"—*Fred W. Whitehouse, M.D.*, Detroit

3:20 Intermission

3:30 "The Oral Hypoglycemic Drugs"—*Francis D. W. Lukens, M.D.*, Philadelphia, Pennsylvania

4:00 Panel Discussion on "Special Considerations in Diabetic Management"
Moderator: *George C. Thosteson, M.D.*, Detroit
Panelists: *Stefan S. Fajans, M.D., Robert D. Johnson, M.D., Francis D. W. Lukens, M.D.*, and *Fred W. Whitehouse, M.D.*

Clinical Society—Annual Meeting

P.M.

6:30 Reception and Dinner
Chairman: *Ralph L. Fitts, M.D.*, Grand Rapids
Speaker: *Francis D. W. Lukens, M.D.*, Philadelphia, Pennsylvania—"Comments on Ketogenesis"

Michigan Academy of Physical Medicine and Rehabilitation—6:30 dinner; 7:30 business meeting; 8:00 scientific program. Speaker, Jack Lapides, M.D., Associate Professor of Surgery, University of Michigan; topic, "Vesicostomy"—all in Room 1607 of the Sheraton-Cadillac Hotel.

WEDNESDAY, MARCH 8, 1961

Michigan Medical Alumni Society—12:00 p.m. reception and luncheon in the English Room of the Sheraton-Cadillac Hotel, Detroit.

Michigan Committee on Trauma, American College of Surgeons and the Detroit Academy for the Surgery of Trauma—12:00 noon reception-luncheon-meeting in the Sheraton Room of the Sheraton-Cadillac Hotel, Detroit.

Michigan State Pharmaceutical Association—dinner, 6:00 p.m. in the Sheraton Room of the Sheraton-Cadillac Hotel, Detroit (invitational).

Board of Michigan Academy of General Practice—12:00 noon luncheon-meeting in the Mason Room, Sheraton-Cadillac Hotel, Detroit.

THURSDAY, MARCH 9, 1961

Conference for Residents, Interns, Senior Students of Michigan—2:00 p.m. in the English Room of the Sheraton-Cadillac Hotel, Detroit.

Michigan Cancer Coordinating Committee—12:30 p.m. luncheon in the Sheraton Room of the Sheraton-Cadillac Hotel, Detroit (invitational).

Michigan Health Officers Association—6:00 p.m. reception-dinner-meeting in the West Room of the Sheraton-Cadillac Hotel, Detroit. Speaker is Emily Sargent, R.N., Director, Detroit Visiting Nurse Association, who will talk on "Home Care of the Patient as Related to Nursing and Other Home Service."

Operating Room Nurses Institute—Thursday and Friday, March 9-10, 1961.

Thursday, March 9, 1961

8:00 a.m. to 4:00 p.m.

Registration—Mezzanine Floor, Sheraton-Cadillac Hotel

9:00 to 11:30 a.m.

Meeting—English Room, Sheraton-Cadillac Hotel

A.M.

9:00 Greetings: *Mrs. Harriett Bell*, Chairman, ORN Conference Group, MSNA

9:10 Presiding: *J. Jane Hannula*, Chairman, Program Committee, ORN Conference Group, MSNA
"Security Is Everybody's Business"—*Avis J. Dykstra, R.N.*, Assistant Executive Director, MSNA

10:00 Coffee Break

10:20 "Effective Personnel Policies Attract Valuable Employees"—*Russell Reister*, Personnel Director, University of Michigan Medical Center, Ann Arbor

11:30 a.m. to 2:00 p.m.

Lunch—visit exhibits on fourth floor of Sheraton-Cadillac Hotel

2:00 to 4:00 p.m.

Meeting—Detroit Leland Hotel
"This Is Your Job, Employee"—Role Playing
Presiding: *Helen Bozvick, R.N.*, Detroit
Employment . . . Orientation . . . Evaluation
Question and Answer Period

Friday, March 10, 1961

8:00 a.m. to 4:00 p.m.

Registration—Mezzanine Floor, Sheraton-Cadillac Hotel

9:00 a.m. to 12:30 p.m.

Meeting—English Room, Sheraton-Cadillac Hotel

A.M.

9:00 Presiding: *Mrs. Jayne Robinson*, 2nd Vice Chairman, ORN Conference Group
"The Present Status of Chemical Disinfection"—*Earle Spaulding, Ph.D.*, Professor and Chairman, Temple University School of Medicine, Philadelphia, Pennsylvania

10:00 Coffee Break

10:20 Question and Answer Period

11:00 "Observations of Soviet Surgery"—*W. H. Steffensen, M.D.*, Grand Rapids

12:30 to 2:00 p.m.

Luncheon—Colonial Ballroom, Detroit-Leland Hotel
Presiding: *Mrs. Harriett Bell*
"Another and a New Look"—"Operating Room Conference Group of the ANA"—*Sophia A. Larsen, R.N.*, Chairman, ANA-ORN Conference Group

2:30 to 4:00 p.m.

Meeting—English Room, Sheraton-Cadillac Hotel

P.M.

2:30 Presiding: *Hazel Brown*, 1st Vice Chairman, ORN Conference Group
"How to Plan a Central Supply Room"—*Mrs. Arlene Howe*, Erie, Pennsylvania, Nursing Consultant, American Sterilizer Company

3:15 "How Central Supply Room Services Operating Room and Other Hospital Units"—*Esther Anderson*, Central Supply Supervisor, Harper Hospital

2:30 Special Program for OR Clinical Instructors for Professional Student Nurses
Presiding: *Wilda Rush, R.N.*, Secretary, ORN Conference Group

4:00 Adjournment

Michigan State Medical Assistants Society—Fourth Annual Educational Seminar, 9:00 a.m. to 3:30 p.m. meeting at the Pick-Fort-Shelby Hotel, Detroit, Michigan.

Thursday, March 9, 1961

Theme: "Medical Techniques for Medical Assistants"

Morning Session—9:00 a.m. to 12 M

A.M.

9:00 Registration—Crystal Room Foyer

10:00 Welcome
Mrs. Betty Lou Willey, President, Michigan State Medical Assistants Society
Introductions
Mrs. Esther G. Regnaert, Chairman of Seminar

10:15 The L. Fernald Foster Memorial Lecture—"Medical and Professional Ethics in the Doctors Office"—*Donald N. Sweeney, Jr., M.D.*, General Surgeon, Detroit, Michigan, Director of Michigan Medical Service, and Michigan Cancer Foundation, MSMS Committee on Ethics

11:15 Film—"The Voice of Your Business
Michigan Bell Telephone Company

11:30 Movie—"The Invisible Enemy"
Civil Defense Production

Luncheon—12:15 p.m.
Terrace Room

P.M.

1:30 "Understand the Purpose of Clinical Laboratory Procedures."—*Alfred Golden, M.D.*, Pathologist, Director of Jennings Memorial and Alexander Blain Hospital Laboratories, Detroit, Michigan

2:30 "Radiation Hazards in Diagnostic and Therapeutic Radiology"—*Robert S. Ormond, M.D.*, Radiologist, Department of Radiology, Henry Ford Hospital, Detroit, Michigan

3:30 Close

FRIDAY, MARCH 10, 1961

Operating Room Nurses Institute—see complete program listed under Thursday, March 9.

Michigan Society of Obstetrics and Gynecology—2:30 to 4:30 p.m. meeting, 5:30 p.m. social hour, 6:30 p.m. banquet and evening program—all in the Grand Ballroom of the Sheraton-Cadillac Hotel, Detroit, except the social hour which will be held in the English Room.

Michigan Heart Association—6:30 p.m. dinner meeting in West Room, Sheraton-Cadillac Hotel, Detroit.

* * *

Wayne State University College of Medicine Alumni Association will maintain an Alumni Headquarters suite in the Sheraton-Cadillac Hotel during the Michigan Clinical Institute. All alumni, their guests, and friends of Wayne State are cordially invited to visit the headquarters.

Schedule of Meetings of MSMS Council for 1961

Tuesday, March 7	Sheraton-Cadillac Hotel, Detroit (preceding Michigan Clinical Institute)
Wednesday, April 19	MSMS Headquarters Bldg., East Lansing
Saturday, June 3	MSMS Headquarters Bldg., East Lansing
Thursday-Friday-Saturday, July 13-14-15	Mackinac Island
Sunday, September 24, and Thursday, September 28	Pantlind Hotel, Grand Rapids
Wednesday, November 15	MSMS Headquarters Bldg., East Lansing
Wednesday, December 13	MSMS Headquarters Bldg., East Lansing

(Turn to Page 164)

Michigan Medical Meetings and Clinic Days

February 8-10	American Academy of Occupational Medicine	Statler Hotel, Detroit
March 8-10	Michigan Clinical Institute	Sheraton-Cadillac Hotel, Detroit
March 17	Michigan Society of Gerontology	Durant Hotel, Flint
April 6	Ingham County Clinic Day	Jack Tar Hotel, Lansing
April 26-29	American College Health Association	Detroit
April 27-29	American Academy of Neurology	Sheraton-Cadillac Hotel, Detroit
May 3	Wayne State University Clinic Day and Alumni Reunion	Fort Shelby Hotel, Detroit
May 22-25	Michigan Health Council	Flint Community College
June 16-17	Upper Peninsula Medical Society	Menominee
June 19-21	University of Michigan Conference on Aging	Ann Arbor
July 27-28	Coller-Penberthy Clinic	Park Place Hotel, Traverse City

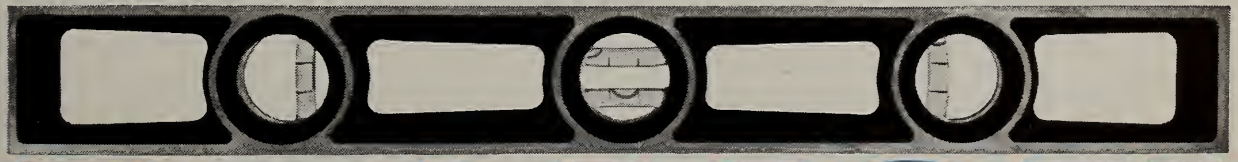
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HIGHLIGHTS of The Council

Meeting of December 14, 1960

A total of seventy-eight items was considered by The Council at its December meeting which was attended by 21 of the 23 members. Items of chief importance were:

- Progress report on new MSMS Headquarters Building was presented by President K. H. Johnson, M.D., who recommended that the dedication date be set for the first week in June. The Council decided on Sunday, June 4, for the formal dedication of the building. The matter of seeking memorial gifts was referred to the Big Look Committee for study and recommendation.
- Presidents Program. Resolution No. 25, adopted by the 1960 House of Delegates to institute the Presidents Program, was reviewed and The Council went on record as being highly in favor of the Presidents Program and recommended its early implementation by all involved—county medical societies, members, associations and organizations.
- Dates and places for 1961 meetings of The Council, nine in number, were decided.
- Wm. M. LeFevre, M.D., of Muskegon, Chairman of the County Secretaries Committee, reported on content of new Handbook for component society secretaries, to be distributed at the County Societies Seminar of January 28-29 in East Lansing.
- County-State Society Nights have been arranged by five component societies (Barry, Calhoun, Genesee, Muskegon, North Central), reported Council Chairman H. J. Meier, M.D., of Coldwater.
- Actions of the November, 1960 AMA House of Delegates Session were reported by Wm. A. Hyland, M.D., of Grand Rapids, Chairman of the Michigan Delegates to the AMA; the report, accepted with thanks, was referred to the Editor for publication in JMSMS.
- Appointments: Chairman Meier presented the personnel of Committees of The Council for 1960-61, which received approval; he also announced he had appointed Wm. Bromme, M.D., Detroit, as Chairman of Committee to Arrange 1961 Conference for Residents-Interns-Senior Medical Students, with Doctor Bromme to select members of the Committee; he reported that President Elect Otto K. Engelke, M.D., of Ann Arbor had been added to the Centennial Committee.

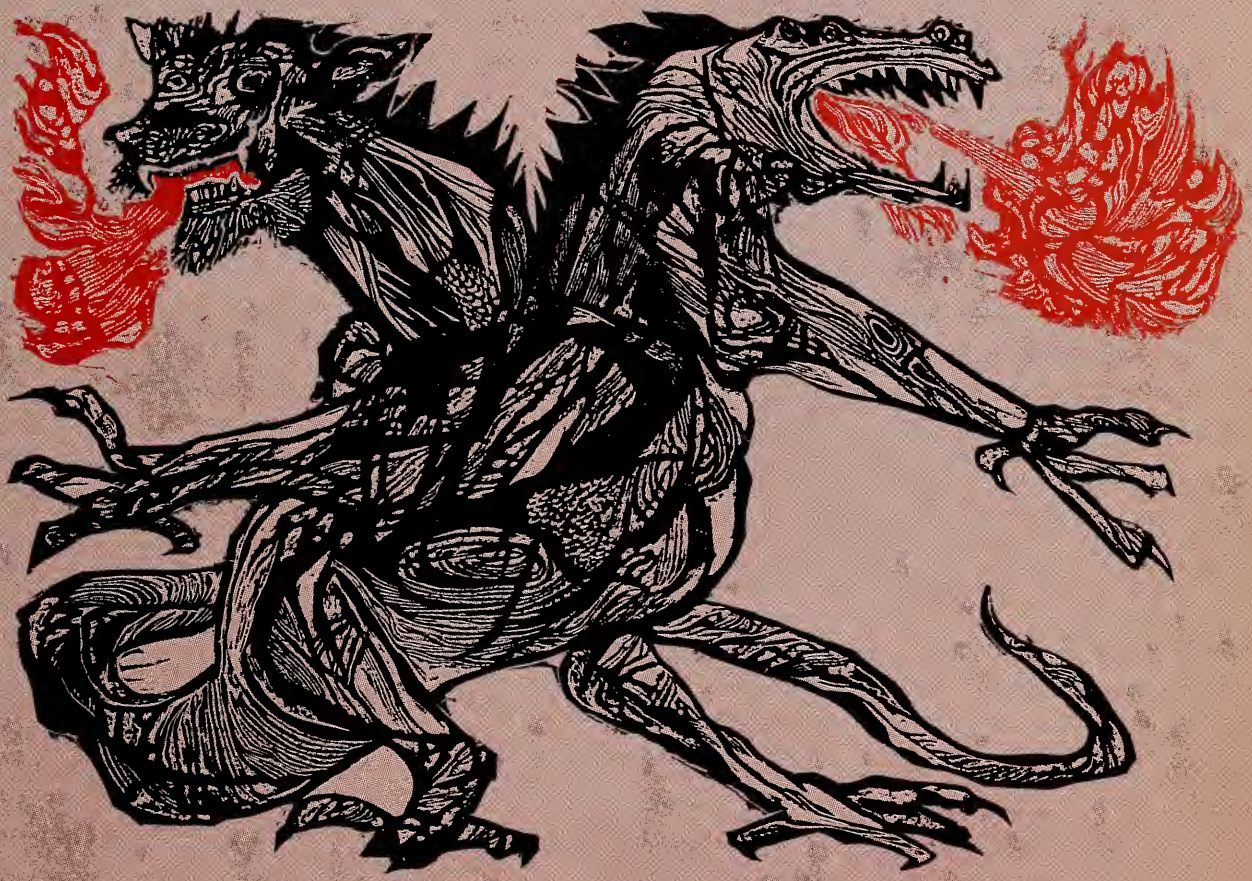
 Howard G. Benjamin, M.D., Grand Rapids was chosen as General Chairman of Arrangements for the 1961 MSMS Annual Session; Dr. Engelke was appointed MSMS representative to the Michigan Livestock Health Council so that the advice of medicine could be available when animal diseases communicable to man are being considered.
- The question of G. Thomas McKean, M.D., Detroit, President of Michigan Medical Service, re procedure to be used by MMS in referring mediation matters to county medical societies was decided by The Council: matters formerly referred to Councilor District Medical Care Insurance Committees now may be forwarded to the proper county medical society for referral to its own mediation or other appropriate committee.

 Progress report on Michigan Medical Service was presented by President McKean who stated (a) that the question of Technical Surgical Assistants is still under study by the MMS Board of Directors; (b) that a new Public Relations Committee of MMS is working on a program to inform the public about its policies; (c) another Michigan Medical Service committee is working toward development of major medical coverage; (d) that 54% of federal employees under the new insurance program have chosen Blue Shield coverage.
- Committees of the House of Delegates. Speaker J. J. Lightbody, M.D., Detroit stated that, in accordance with Resolution 43 of 1960 MSMS House of Delegates, he had appointed the following committee to study problem of indigent doctors of medicine: Charles W. Sellers, M.D., Detroit, Chairman; Allison R. Vanden Berg, M.D., Grand Rapids; Perry C. Gittins, M.D., Detroit; and L. A. Drolett, M.D., Lansing; Doctor Lightbody also announced that, in accordance with Resolution 54 adopted in 1960 re revising the rules and order of business for the Annual Session, these recommendations will be implemented in the plans for the 1961 House of Delegates session.

 The Speaker also reported appointment of the House of Delegates Committee to Review Constitutions and Bylaws; L. J. Bailey, M.D., Southfield, Chairman; R. R. Cooper, M.D., Grosse Pte.; A. B. Gwinn, M.D., Hastings; F. P. Rhoades, M.D., Detroit; J. A. Witter, M.D., Highland Park; and Lester P. Dodd, LL.B., ex officio, Detroit.
- 1961 MCI. The proposal of the MSMS Mental Health Committee (John M. Dorsey, M.D., Detroit, Chairman) to sponsor a program on care of

(Continued on Page 166)

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Highlights of The Council

(Continued from Page 164)

aged patients in nursing homes, for Thursday evening, March 9 during the 1961 MCI, was approved by The Council.

- The 1960 MSMS House of Delegates approved the Annual Report of MSMS Committee on Study of Prevention of Highway Accidents which included recommendation that MSMS write to auto manufacturers deploring the present status of not incorporating more safety features in their products. Draft of a letter on this subject by John R. Rodger, M.D., Bellaire, Chairman of the Committee, was authorized to be sent to auto manufacturers, with contents to be released to the public.
- The recommendation of the Wayne County Medical Society that there be only one group health and accident plan and one group life insurance plan for all physicians in Michigan was referred to the MSMS Committee on Insurance for study and report back to The Council.
- O. B. McGillicuddy, M.D., of Lansing, Chairman of the Finance Committee, reviewed the monthly Financial Report and other items considered by the Finance Committee at its December 14 meeting, including purchase of new dictating equipment, cleaning arrangement for new MSMS building, and expense of inviting county society representatives to January 12 MSMS Maternal Health Committee meeting.
- Lester P. Dodd, LL.B. of Detroit, MSMS Legal Counsel, reported on a number of matters including (a) mail order practice of handling laboratory work for doctors; (b) exemption of doctors from jury service; (c) ethics and legality of physicians taking listings in yellow pages of telephone directory in an adjoining county in which physician does not reside; (d) necessity for obtaining a doctor's consent for release of information on a patient by Social Security Administration to a local county Bureau of Social Aid; (e) liability when a druggist refills a prescription without a doctor's knowledge or consent; (f) surgical consent forms.
- Public Relations Counsel Report included presentation of second issue of *Medical Economic Currents*; report on career conferences; plans for 1961 Michigan Clinical Institute news conference; reprinting of pamphlet "In Planning Your Career"—10,000 copies being authorized; resignation of Mr. Richard N. Philleo as MSMS Field Secretary and employment of Morris A. Riley.
- Committee Reports: The following were given consideration: (a) ad hoc Committeee Concerning Practice of Chiropody, meeting of October 6; (b) Michigan Clinical Institute Program Committee, October 18; (d) Maternal Health Committee, October 20; (e) Michigan Clinical Institute Television Committee, October 20 and November 3; (f) Geriatrics Committee, November 15; (g) Mental Health Committee, November 22; (h) Committee on Scientific Work, November 23; (i) Advisory Committee to Executive Director, December 14.
- Michigan Health Commissioner A. E. Heustis, M.D., distributed copies of "Health Service for Michigan People, 1961" which contained digest of new items in State Health Department budget request, together with overall summary of the request.
- Reports from G. E. Millard, M.D., Detroit, on national meeting of American Association of Medical Assistants held in Dallas, Texas; from C. P. Anderson, M.D., Detroit, on the 11th County Medical Societies' Conference on Disaster Medical Care held in Chicago; from Richard N. Philleo on November 27 meeting on care of the aged held in Washington, D. C.
- MSMS representatives to (a) AMA Medical Legal Conference Regional meeting: Legal Counsel Dodd was authorized to attend this April meeting if he so desires; (b) Professional Convention Management Association: Executive Director Wm. J. Burns was authorized to attend this January meeting if he so desires.

MSMS Cooperates

The Michigan State Medical Society will be represented on the new Michigan Livestock Health Council by President-Elect Otto K. Engelke, M.D., Ann Arbor.

Organized in December, the Council is designed to study livestock diseases communicable to man, make recommendations on regulatory education and research programs, plan and implement statewide health programs and to review progress in this field. The 48-member council includes representatives from other associations concerned with health, agriculture, marketing and veterinary and human medicine.

Co-sponsor Course at U-M

A Postgraduate Course in Rheumatic Fever, Rheumatic Heart Disease and Congenital Heart Disease will be presented at the University of Michigan Medical Center, March 13-17. Outstanding speakers have been obtained for this course, co-sponsored by the Michigan Heart Association, University of Michigan Medical Center, Wayne State University College of Medicine and the Michigan State Medical Society.

The Importance of the Public Image Versus Reality

Excerpts of an address by Pierre D. Martineau, Director of Research and Marketing, Chicago Tribune, at the AMA Public Relations Institute, September 1, 1960, Chicago.

Whenever new ideas appear which attain wide currency, they seem to go through a cycle and eventually become popularized and bastardized.

Very often the public becomes so fatigued hearing about them that it pretends they have lost their validity. Nevertheless, the original force of the concept still remains. I could mention psychoanalysis, evolution, and relativity just as examples. The concept of the image of a brand, a product category, an organization, a profession, or an idea seems to be going through the same cycle.

However much you have encountered this, it is still important to realize exactly what is meant by the public image of doctors and the AMA because in very large measure this will play a key role in the future course of political and public behavior involving you people.

* * *

MY ROLE HERE is to lay a theoretical groundwork for subsequent discussion of the subject. In order to proceed from the concrete to the abstract and to make perfectly clear what I am driving at, let me recite some workaday experiences with very mundane things.

Westclox introduced a wrist watch which is not selling very well. Why? Because the associations in people's mind of Westclox are those of big alarm clocks, not beautiful watches. They sought to open new channels of distribution by selling them through drug stores. What kind of watches are customarily sold in drug stores? Mickey Mouse watches and cheaper watches like Timex.

The Simoniz Company has embarked on a program of diversification with only indifferent success. Why? Because in the public mind Simoniz is tied to associations of a hard, tough wax. Too many people recall long hours of hard work helping their fathers simoniz the family car.

* * *

THE POINT I AM TRYING to make is that every well-known brand is defined in the public mind by what it is and most importantly by sets of psychological associations which may or may not be true. Both of these constitute the brand image and it is this image that humans react to rather than reality. All of our stimuli from the outside are filtered through this image.

I have talked about individual brands. But the same things are true of whole product categories. The margarine makers have made perfectly clear that their product is fortified by vitamins to have all the food value that butter has, it has many advantages of use, and it costs only half as much. If it is colored, so is butter. But there is still more butter sold than margarine because of the associa-

tions tied to margarine versus these country-charm and quality notions attached to butter.

At some point in time for the individual, these images are formed, partly by experience but mostly by word of mouth. Once they are formed, they become stereotypes extremely difficult to alter. It is these images people have which far more often determine their behavior than the actualities. We bend the actualities to fit the image. We believe what we want to believe.

* * *

THIS IS ONE OF THE fallacies in our heritage of rationality—that if we give people the facts, then we will win our case. "Know the truth and the truth shall make ye free" is handed down to us as a credo. But any deep-set image becomes more and more embedded in feeling. And you rarely change people's feelings by presenting them information, which rarely gets to their feelings.

Sophisticated American marketers today realize that even though most products in the same category are relatively indistinguishable, consumers have different images which determine their purchasing. Although they in laboratory conditions cannot tell the difference between cigarettes or liquor or detergents or bread, they firmly believe there are differences once they see the products labelled.

* * *

IF MY THESIS SEEMS an unkind commentary on an educated, high-stage civilization such as ours, the truth is we prefer to act toward our illusions. I don't suppose 5% of the stars in Hollywood and on TV use their own names. Their agents adorn them with romantic names which transmute their images. Even when I know that Rock Hudson was born Roy Fitzpatrick, I still act toward him as Rock Hudson. In other words, the semblance of truth is more important than truth itself.

This does not mean these images cannot be modified. Of course they can. Chevrolet a few years ago discovered its image was that of an uninteresting, old folks, low price car with none of the associations attached to the up-and-coming Ford such as smartness, youthfulness, modernity, the epitome of modern suburbia. But Chevy—no longer Chevrolet—transmuted its image into something entirely different. In this model year Chevy sales were twice those of Ford. Pepsi Cola changed itself from a cheap soft drink into the image of lightness and the modern young wife.

But in this attempt to change an image, the most common error I encounter is the belief that we can cure public misunderstanding merely by supplying information which is usually directly contrary to what people believe and feel.

After a study in 1954 revealed that 57% of American adults did not even know what a common stock was, the New York Stock Exchange embarked on a program of "public education." After 6 years of "education," another study has just been completed which showed that now 56% of American adults did not know what a common stock was. Another study of stockholders revealed that 57% of them could not name one single product manufactured by the companies in which they owned stock. Yet Wall Street complacently feels it has changed its image. I don't think it has at all. The public has simply found another villain it dislikes worse than Wall Street: Madison Avenue.

* * *

THEREFORE, IN CLOSING, I would state you have your work cut out for you, in view of the hostilities I seem to encounter among highly educated people. In both cases you have two factors: doctors as they really are, and doctors as the public sees them; the American Medical Association as it is and the image of the AMA which is held by the public, the politicians and the influential intellectuals. I hope I have made it clear that you cannot hold up your hands in anger and say that's not the way you really are. It is all imperative that you come to grips with these images of the doctor and of the AMA.

Present Family Doctor TV Show in Lansing

A special one-hour telecast demonstrating the various activities in a doctor's office was presented recently over WMSB, Channel 10, Lansing. Cooperating were the MSMS, Ingham County Medical Society and the Michigan Health Council.

Television cameras took viewers through a general physical examination and a surgical proceedure. An examination for breast cancer, application and removal of a cast and a demonstration of what happens when the mother-to-be makes her monthly visit to the doctor were included.

The presentation was the fourth in a series. The first show was staged in Detroit with the Wayne County Medical Society, the second in cooperation with the Kalamazoo Academy of Medicine, the third with the Kent County Medical Society.

The Lansing show featured David Siegel, M.D., as medical moderator, describing the actions and interviewing the participants: Frederick C. Swartz, M.D.; John H. Packer, M.D.; Richard W. Pomeroy, M.D.; E. J. Robson, M.D.; and M. S. Sharp, M.D., assisted by Mrs. Irene Helms, medical technician.

Summing up the hour-long special feature was MSMS President Kenneth H. Johnson, M.D., who explained that the purpose of the show "was to provide a clearer understanding of good medicine as practiced in a doctor of medicine's office."

Hospital Admissions Up 75 Per Cent Since '40

A study of hospital records reveals that admissions to general and special hospitals in the United States increased from 74 per 1,000 persons in 1940 to 130 per 1,000 during 1959.

Advances in medical science, however, helped reduce the lengths of stay from an average of 13.7 days in 1940 to 9.6 days in 1959. This decrease was the leading reason why the number of days in all hospitals for each 1,000 persons declined slightly from 2,839 in 1940 to 2,811 in 1959.

Although the hospital admission rates are 75 per cent higher than 20 years ago, the days in hospital per person for the total population was the same for 1940 as 1959.

The average number of days each American spent in general and special hospitals, mental hospitals, and special tuberculosis hospitals was the same in 1959 as in 1940, down after a peak of 3.9 days a person in the wartime year of 1945, and an average of 3.1 days a person in 1951, 1952 and 1953.

The reduction in the length of hospital stays played a key role in keeping the demand for hospital services within manageable bounds. If the average length of stay in general and special hospitals had remained at its 1940 level of 13.7 days through 1959, the rise in admissions would have produced 1,789 days in these hospitals for each 1,000 persons, some 43 per cent above the actual figure of 1,254 days.

These figures are from a report of the Health Insurance Institute.

* * *

Says Final "Kintner" Regulations Disappointing

The long awaited Regulations for "Kintner" type associations have now been issued in final form by the Internal Revenue Service, reports the AMA Law Department.

Physicians who looked forward to qualifying for tax-deferred pension plans through the establishment of unincorporated medical groups taxable as corporations will in most instances be disappointed, says the AMA law department.

In the Kintner and Galt cases, it was held that even though under local laws doctors and other professional persons cannot form a corporation, these laws do not necessarily prevent an association of doctors from being taxed as a corporation under the Internal Revenue Code. The court in each case held that the clinic involved more nearly resembled a corporation than a partnership and therefore the physicians in the group could participate in a tax-deferred pension plan.

The AMA Law Department says it was hoped that the Regulations would implement the holdings in the Kintner and Galt decisions. However, in the opinion of the AMA Law Department, the Regulations amount to non-acquiescence on the part of the Commissioner.

The Regulations state that an unincorporated organization shall not be classified as an association unless it has more corporate than non-corporate characteristics. The extent to which the following corporated characteristics are present or absent will determine whether an organization will be classified as a partnership or an association: (1) continuity of life, (2) centralization of management, (3) limitation of liability for debts to organization property, that is, no personal liability on the part of members, and (4) free transferability of interests.

Health Care of the Aged— What Insurance Industry is Doing

With public interest in this problem at an all time high, one might well ask what our private insurance industry is doing about it. "Seven Principal Methods" are being employed currently by insurance companies to provide the aged with medical and hospital care expense. They are:

1. The continuation of insurance on older active workers under group insurance.
2. The continuation of group insurance on retired workers and their dependents, generally with part or all of the premium paid by the employer.
3. The continuation on an individual policy basis of coverage originally provided by group insurance by virtue of the right on the part of the employee to convert his group coverage.
4. The new issuance of group insurance at advanced ages, to such groups as associations of retired persons, retired civil servants or Golden Age Clubs.
5. The continuation into later years of individual insurance purchased in the productive years, with at least 51 insurance companies writing coverages guaranteed renewable for life.
6. The new issuance of individually purchased policies at advanced ages, with at least 165 insurance companies issuing policies at age 65 and over.
7. The issuance of insurance that becomes paid-up for life at age 65.

—*Quoted from* Query, *publication of the American Society of Chartered Life Underwriters (December number).*

Specialists of the Chamber of Commerce of the United States estimate that by next December, seven out of ten of the aged needing and wanting hospital-surgical insurance will be covered by such policies. By 1969, nine out of ten persons will be so insured, they predict.

A Word to the Wise

All doctors of medicine are advised to make sure that they have the proper receipts and vouchers to substantiate income tax deductions for entertainment and travel expenses. The Internal Revenue Service has added additional information requirements on Schedule C of the return. Apparently, these deductions will be spotlighted by government auditors when your return is checked. It is possible that it might be a couple of years before they get around to discussing the matter with you, so it is best to keep a good record of your expenditures in this area. If you have not kept good records, go back and try to secure receipts wherever possible while the matter is still fresh in your mind. Remember when Uncle Sam does talk to you, you have the burden of sustaining the deductions.

—*Illinois State Medical Society Newsletter,* No. 31.

Blue Shield Payments to Doctors Reach All Time High in 1960

More than 1,847,000 persons enrolled in the 74 Blue Shield Plans located in North America during the first nine months of 1960, and during the same period the Plans paid out approximately $550,000,000 for care rendered to members.

"Of special significance is the fact that the $550,000,000 paid to physicians was an all-time high in payments for a nine-month period, and represented approximately 91 per cent of the total income of all Blue Shield Plans," the national association indicated in its report. At the same time, the 74 Blue Shield Plans were reported to have expended less than 10 per cent of total income for administrative expenses.

The national association also said in its report that membership in the 74 Plans reached 46,640,348 as of September 30, 1960—an enrollment of one out of every four Americans. Included in the enrollment figures for the first time are approximately 938,000 Federal workers who selected Blue Shield under the recently enacted Federal Employees Health Benefits Program.

Texas Society of Internal Medicine adopted a relative value schedule at its first annual meeting.

Foreword on Articles On Medical Writing

J. P. Gray, M.D.
Detroit, Michigan

CLINICAL 191

AMONG physicians and others who read "the medical literature," few will deny that the quality thereof frequently is less than scholarly. This observation is not new. Alan Gregg, in 1943, wrote that "The common level of medical and scientific writing in our professional books and journals already constitutes the most serious internal limitation to medical education and research." The intervening eighteen years have brought less improvement than needed to ease the limitation cited. Actually, communication, in medicine as in other scientific fields, has become increasingly more difficult, if not as a result of, certainly as a concomitant of, intensified research and resultant extension of knowledge in the post-war period.

American Medical Writers' Association

First organized in 1940, in Rock Island, Illinois, by six editors of medical journals during the annual meeting of the Mississippi Valley Medical Society, the Mississippi Valley Medical Editors' Association was reorganized in 1948. At that time, its scope was widened and its name was changed to the American Medical Writers' Association, the first, and for many years the only, national organization to have the stated objective ". . . to help maintain and advance high standards in communications concerning medicine and allied sciences . . ." The Association, under a new constitution adopted in 1951, was incorporated not-for-profit under Illinois law; affiliation with the American Association for the Advancement of Science was accomplished in 1952. AMWA now has more than 1300 members and has its own *Quarterly Bulletin*. Four regional chapters exist: in New York (Metropolitan) organized in 1956; in Philadelphia (Delaware Valley) organized in 1956; in Washington (Mid-Atlantic) organized in 1956; and in Detroit (Michigan) organized in 1957.

Three significant developments resulting from the Association's activities merit brief description.

Universities' Curricula in Medical Writing

A basic objective of the AMWA Educational Committee was achieved in 1954 when the Universities of Illinois (Urbana), Missouri (Columbia), and Oklahoma (Norman) announced the establishment of curricula in medical writing in their Schools of Journalism. For the first time, persons interested in opportunities for educational experience leading to baccalaureate degrees, with major work in journalism and minor in medical sciences, were offered

planned curricula in recognized universities' schools of journalism. These permit such persons to qualify educationally for positions in medical journalism, in medical publishing, and in related fields. Over the years, the influence of these three schools will be a major factor in medical communications.

Medical Manuscript Editing Service

The AMWA Medical Manuscript Editing Service, established in 1952 as a non-profit activity, provides competent editorial advice, for a fee, to members of the Association. The service is available also to medical writers not members of the Association, especially to those who have not written for publication before; but fees for them are 50 per cent higher.

Visiting Lectureship on Medical Writing

The third basic goal, the Association's hope that a traveling or visiting lectureship might be established, was realized late in 1954. The Visiting Lectureship on Medical Writing, made possible by support from Parke, Davis & Company, was activated in 1955. Under this sponsorship, the lecturer is available, on invitation from deans and other responsible administrative officers, at no expense to them, for lectures on medical writing at schools of medicine and at related institutions in the United States and in Canada. As this Foreword is written (summer of 1960), the lecture, "Communications in Medicine: on Writing," adaptable to various groups, has been presented more than 150 times in five and one-half years (1955-1960). Visits and revisits have been made to thirty-four American and to six Canadian schools of medicine and to related institutions (schools of dentistry, schools of veterinary medicine, hospitals, clinics, government facilities, research institutes, et cetera). The total number of persons addressed exceeds 12,000.

Special Issue of The Journal

Late in 1959, the Michigan Chapter of AMWA, with total active membership of less than twenty, undertook the planning of a special issue of THE JOURNAL MSMS and the writing of several papers therefor, on various aspects of medical writing believed appropriate and of possible interest to members of MSMS and to other readers. The Editor, Doctor Haughey, with approval of the MSMS Council and of its Executive Committee, scheduled this special issue for February 1961.

Objective

In the AMWA Visiting Lectureship, support for the single lecture approach was found in a statement written by Eugene McCartney, Ph.D., Editor Emeritus, University of Michigan Press: "An awareness of shortcomings must precede all attempts at betterment." From the single lecture, little more could be expected than arousal of interest in the need for improvement in quality of medical writing. Indeed, this, only, is the stated objective of the lecture as basic to all attempts at betterment. No attempt is made in the lecture to teach medical writing. Similarly, the papers appearing in this special issue of THE JOURNAL are not to be thought of as an attempt to present a manual or guide on medical writing: our whole objective lies in arousal of awareness of need for improvement in quality of writing . . . particularly in writing for publication, but, as importantly, in writing clinical records, letters, and other forms . . . writing as a means of communication in medicine. As "an awareness of shortcomings must precede all attempts at betterment," so an aroused awareness of need for improvement in quality of writing is the first step toward improvement.

Readers of THE JOURNAL will find some repetition in the several papers in this special issue. Similarly, differences of opinion will be found on some points. These were expected to obtain, under the circumstances, in which several authors were invited to write on various aspects of medical writing. Authors were asked to keep in mind the ultimate objective of the special issue; but they were not discouraged from making specific suggestions, related to arousal of interest in need for improvement in quality of writing, that might be helpful to medical writers. So, as educators have accepted repetition and difference of opinion, both within reasonable limits, as sound teaching techniques, we hope readers of THE JOURNAL will look upon such attributes in these selected papers as justifiable emphasis of basic principles in good writing.

The Michigan Chapter of AMWA hopes that THE JOURNAL's readers will be as richly rewarded for reading the articles as we have been rewarded in writing them!

(List of references for this foreword will be found in the amalgamated list of references on medical writing for all papers in this special issue of THE JOURNAL *on page 234.)*

The Roots of Medical Writing

Alfred H. Whittaker, M.D., F.A.C.S.
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Ralph E. Sloan
Dearborn, Michigan

YOUNG men sat on stone benches and listened attentively to the aged teacher who faced them. The classroom was one of many in the eight-story building constructed of clay bricks. Outside, immaculate gardens provided ever-changing beauty as a setting for statuary art. The students were richly garbed and their jewels, exquisitely inscribed, gave evidence that they were of the upper class.

The professor lectured on treatment for gall stones and for bladder troubles, for wounds, for heart trouble and for other ailments with which physicians of the time were concerned. As he spoke, he referred to clay tablets covered with writing—some from that medical school and others borrowed from libraries in other parts of the country.

The school was in the Temple of Baal—in the country of Babylonia, a part of what we know now as Iraq. The time was about 3,000 B.C.—15,000 generations of man before the atom bomb. This period was not the beginning of civilization, but it was the epoch in which reason began to assert its influence upon human destiny. Babylonian culture still contained considerable mysticism and magic, but to that time we can trace the earliest indications of present western civilization. We know that the Babylonian Empire was the culmination of centuries of development but not until then was man able to leave a resonably comprehensive written record of a highly specialized society and a well-organized and classified body of knowledge.

The Summarians who conquered, then developed Babylonia apparently had controlled the commerce of the world for several thousand years. Their literature and art creations show an advanced state of development that can be traced far into antiquity with increasing difficulty as the manner of communication also becomes more primitive. During centuries of Summarian domination of the western world, cuneiform writing developed from earlier inscription by pictograph. By the time of Babylonian ascendency, this method of permanently recording wisdom and knowledge had made possible the perpetual accumulation and sharing of information throughout the civilized world. Clay was plentiful and gained wide use in construction of buildings and in making utensils, even art objects. Stone was not as readily available in that area, and clay tablets were more easily inscribed; undoubtedly contributing factors to the upsurgence of writing which resulted in libraries containing thousands of clay tablets and to the duplication of tablets for use in widely separated locations. Impermanence of the material precluded survival of clay structures exposed to the elements but excavations have produced small art objects and many records which depict the life of 5,000 years ago.

Reason had become a major factor in the existence of man during the Babylonian Empire. The earliest tablets of prose, hymns and prayers show a high degree of scholarship and of mental discipline. Schools, attached to all of the temples, were attended by boys, by girls and by adults. Special training colleges were available for surveyors, engineers, astronomers, lawyers, priests and physicians. Their writings indicate clearly that Babylonian doctors were good diagnosticians who methodically and systematically examined their patients and prescribed the remedies indicated in the materia medica and pharmacopeia, precisely as today. Prescription tablets gave the best treatment for each disease, and Babylonian

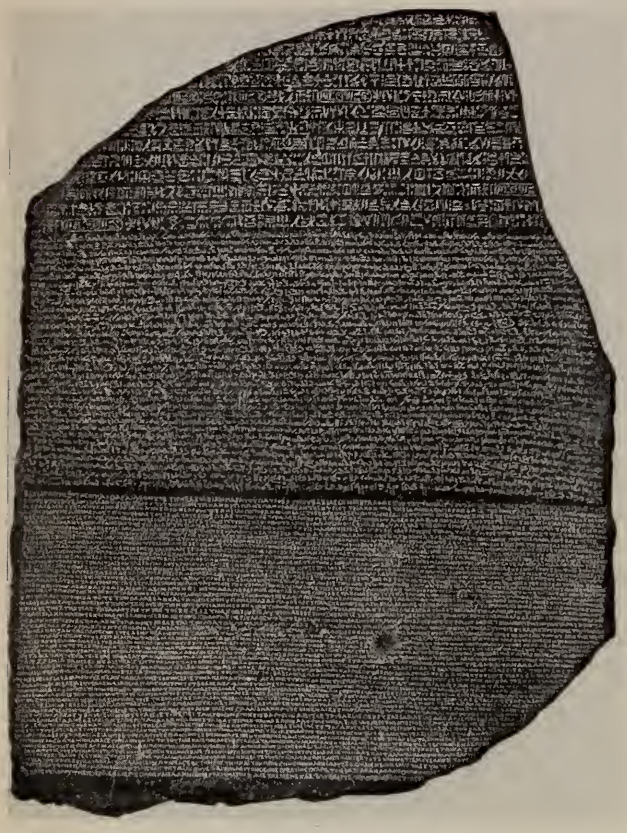
The Author

ALFRED H. WHITTAKER
M.D.



Dr. Whittaker is a Fellow of the American Association of the History of Medicine. Mr. Sloan is editorial consultant for medical and scientific publications. Both authors are members of the American Medical Writers' Association.

physicians included homeopathy and allopathy in their principles of practice. As at present, medical men were paid fees for their services, and their work was given status by law. In the Code of Laws



THE ROSETTA STONE

Discovered by soldiers in Napoleon's army at Rosetta in 1799, the stone bears three inscriptions, the uppermost in Egyptian hieroglyphics, the middle in Demotic (a cursive development of hieroglyphics) and the third in Greek, the last being a translation of the two Egyptian texts. With the help of this inscription Thomas Young (1773-1829) and J. F. Champollion (1790-1832) successfully began the process of decipherment of the old Egyptian language.

promulgated about 2100 B.C. by Hammurabi, there are numerous references to the doctor and to the practice of medicine.

A capable medical faculty existed in Egypt fifty centuries ago, and there is no doubt that Egyptian doctors studied medicine and surgery in the medical colleges of Babylonia. The first flexible and easily handled material upon which to write, papyrus, was manufactured from the pith of the papyrus reed. It is native to southern Europe and was cultivated extensively in Egypt and Greece during the centuries before paper replaced it for general use circa 1000 A.D. Papyri survived only when kept dry by covering desert sands, principally in Egypt where papyri texts dating from 2500 B.C. to 996 A.D. have been discovered. Thousands of papyri taken from Egyptian excavations are written in many languages, including hieroglyphics, ancient scripts, Arabic, Greek and Latin. Most numerous are those in Greek, for that was the official language in Egypt for 1500 years. The Ebers Papyrus and many others shed much light on the work of doctors in Egypt's early history. In the Ebers Papyrus, hieroglyphic references to organs in the human body are copied from corresponding organs of various animals, indicating that Egyptian physicians followed the oriental practice of studying anatomy and practicing surgery with animals rather than men. Egyptian medicine was highly specialized, each doctor concentrating his efforts on only one or two diseases. When Acrodotus went there, he recorded finding doctors who specialized in diseases of the stomach, of the eyes, of the intestines, of the brain, of the heart, and of the nerves.

Oriental and Egyptian civilizations were fused in the rapid rise of a semibarbarous race of Aryan stock to The Great Age of Greece which started about six centuries before Christ. The glories of Greece that form the basic heritage of twentieth century western civilization were preserved in marble, in stone and on papyrus. Before modern times, the supremacy of Greek art, architecture, engineering, philosophy, science and literature were unquestioned. Pre-eminently, the influence of Greece in classical antiquity was intellectual and cultural.

With their development of philosophy and of scientific method, the Greeks were able to break away from oriental influence and to pursue knowledge in many directions. The creative forces of Greek intellect were scattered by waves of colonization, and each colony clung tenaciously to its mother language, religion and social customs. Thus, throughout the Mediterranean world, the achievements of Greeks were reported in the Greek language and taught from Greek writings during five centuries before and a dozen centuries after the time of Christ.

Medical historians are well aware that medicine developed not only in Mesopotamia and in Egypt but also in China and in India. They also know that archaic medicine was much the same everywhere. Here, since our major focus is on medical writing, it is sufficient to point out that the earliest Indian and Chinese texts extant are more recent than those of Egypt and of Mesopotamia. Presumably out of reverence for the past, ancient Indian and Chinese systems of medicine are today being practiced on millions of people. In contrast, Babylonian and Egyptian

systems of medicine ran their course centuries before Christ and gave rise to the Greek epoch in medical discovery and practice.

Recent study has emphasized that in ancient Greece, philosophy and science, medicine particularly, were closely related. It is quite clear that those remarkable people combined a passionate interest in details of their earthly environment with indefatigable attempts to explain and to interpret circumstances of life. They were excellent observers with a compelling sense of wholeness, the oneness, of their lives and the urge to encompass wonders of the world about them in intelligible concepts. Early Ionic philosophers tried to determine the primitive element in nature—air, water or whatever it might be. So medical workers from the earliest time, hit upon the idea of proportion as essential to existence. Alcmaeon of Croton was the first Greek to write a medical treatise, to practice dissection and to discover that the brain is the central organ of the sensory-motor systems. He called the equal and cooperative mingling of the separate elements in human nature "Isomnia" and said "Isomnia is health." So the Greeks wrote that health is upset when balance of the several elements is disturbed; and what he called a "monarchy" causes disease. This sense of proportion permeated Greek medical investigation and powerfully influenced all Greek philosophic thinking and writing. This doctrine of the golden mean, as it came to be called, underlies all Aristotle's ethics as well as his writings on natural history. Alcmaeon and his contemporaries, Anaximenes in particular, also developed a doctrine that the human being was a sort of miniature world and that the human microcosm was in direct relationship in composition and functioning with the macrocosm which is the universe itself. So the earliest medical writing reflects a certain awareness of universality. The two concepts of Alcmaeon were enlarged and extended by Empedocles, sometimes called the father of chemistry, who formulated the dogma of the four elements—fire, air, water and earth. This dogma reigned as authority unquestioned until Phlogiston attempted in the seventeenth century to explain human physiology and showed, for example, with the physiology of breathing, the fundamental inadequacy of the four elements dogma.

The history of man's intellectual progress in understanding and in conquering his external and internal environments is a record of reciprocally related accelerations in time and in complexity. In studying the artifacts of primitives and the crude records of pre-history that have survived, major emphasis usually is placed upon the events *per se* and their impact on physical, social and cultural life. It seems not amiss here, without introducing a "chicken or egg first" controversy, to point out that the civilization established by the Greeks, which is the foundation of our electronic age, was contingent upon communication. In that culture, for the first time, collateral development occurred in many of the arts and the sciences as a result of the ascendancy of reason of accurate observation and of scientific method. These simultaneous developments on all intellectual fronts could not have happened without art forms equal to exacting representation and without a written language adequate for comprehensive recording of fact and of theory, with consequent organization of systematized knowledge, its widespread dissemination, and its perpetuation with rapid increments through education.



MUSEE DU LOUVRE
Scribe accroupi (The seated scribe)

These factors were particularly relevant to advances in the art and in the science of medicine, in which the tangible and the intangible, the objective and the subjective, the experimental and the theoretical, must be not only recognized but also evaluated and reconciled. Under these conditions, writings were produced which have been preserved under the name of Hippocrates; these mark the first great epoch in the history of medicine as a science and as an art relatively free of superstition and of mysticism.

Some seventy writings which compose the "Hippocractic Corpus" are one of the jungles of early literature in which students have found it exceedingly difficult to disentangle any portions which may have originated with Hippocrates himself. Regardless, in the great collection are found Alcmaeon's elementary principles of balance and relationship of the individual to the universe, fuller development of Empedocles' four elements, and the dual motivating impulses evolved by Greek medicine—love and hate; attraction and repulsion; or, positive and negative. Hippocratic writings also portray a sensing of the significance, almost sanctity, of medical efforts; broad interest with distress, in the drugs and medicaments in common use; insistence upon the importance of natural environment in both the physical and the ethical development of mankind; and, unswerving faith that if the physician could attain calm, a sense of proportion and the confidence of his patient, then the healing power of nature was more effective than any system of diagnosis or treatment evolved by man. Intermittently during succeeding centuries, the Hippocratic principles were restated and reaffirmed; even today, 3300 years later, Hippocrates is revered as the Father of Medicine and his oath continues to be the cornerstone of medical ethics.

Aristotle, perhaps best known of Greek philosophers, was a young boy when Hippocrates died. The fathers of both were physicians but, though they had corresponding philosophies and dedication to human welfare, Aristotle's interests were less restricted to medicine. About forty of some 120 works by Aristotle are in existence and are an encyclopedic index to the knowledge of the fourth century B.C. They encompass logic, natural history, philosophy, psychology, ethics, politics and social issues. Aristotle was the greatest scientist of the early world, probably the first true scientist among those of whom we know. His three great books on animals, the *Historia Animalium*, the *De Partibus* and the *De Generation*, are crowded with accurate records of observations on structure, on function and on embryology and constitute the greatest contributions to biology before the seventeenth century.

There is a tendency to regard the contributions of Aristotle as the final ones of Greek civilization, but the greatness of Greek influence extended through Alexandrian civilization and through the Byzantine Empire to the fall of Constantinople. One need only recall the manuscripts of Archimedes and of Euclid, who did for science what Aristotle did for logic. Writings of Euclid reigned longer than did those of any other single teacher, except those in religion, in the world's history. In zoology, Aristotle, indeed, had no close successors, but Theophilistus carried his principles into the field of botany and deeply influenced medical education. Dioscorides, a pharmacologist, became the source of modern botany, and Galen, of modern anatomy and of physiology. Writings of these two were authoritative until the Renaissance.

Turning from Greece to Rome is to turn from a creative and an original civilization to one which, apart from its amazing practical genius, was imitative, and what is imitated is vulgarized. There are exceptions, perhaps, in the poets Lucretius and Virgil; nevertheless, to turn from Aristotle to Pliny is to turn from brilliant original work to rather cheap reproduction. One need only compare the use Aristotle made of animals sent to him by Alexander the Great, during the course of conquests all over Asia, with the slaughter in the arena at Rome of thousands of animals without one Roman publishing a report of study of the beasts.

During a strange interlude in human civilization which began in the fourth century, science became almost non-existent, and fantasy replaced scientific observation. For the next thousand years, literature produced was largely dominated by fable, by heraldry and emblem, and by legend. Though medicine stagnated during those Middle Ages, it had a continuous tradition, perhaps because of its solid groundwork laid by the prolific writing of Hippocrates, of Aristotle and of Galen. In the great thirteenth century, Albertus Magnus, now known as Saint Albert, patron saint of science, among much else produced quite admirable accounts of births. In the fourteenth century, when still there was hardly a single worker in other fields of science, the peasant-surgeon Guy de Chauliac, who became physician to the Pope and who wrote the Grande Chirurgie (1368), though he praised Galen, also euologized the time in life when passion for knowledge creates ability to test the old against experience and to accept or to reject.

During medieval times, there were only tentative ventures in scientific discovery; the history of that period provides fascinating material for sociologic and psychologic study, but only the records of a few more persons of genius—a few poets, a number of artists. Restless forces accumulated during the later Middle Ages to foreshadow rapid transition from one type of civilization to another radically different. As the period drifted into the Renaissance, intellectual and social culture built around the universal

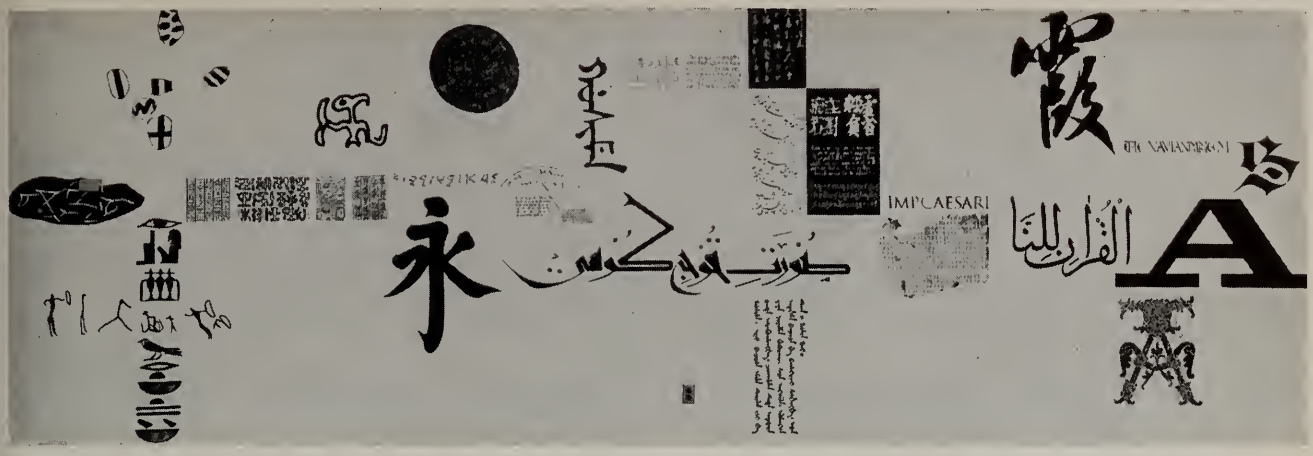


PHOTO-MURAL ON WALL OF ADULT READING ROOM—GROSSE POINTE PUBLIC LIBRARY, GROSSE POINTE, MICHIGAN
(By Herbert Matter as suggested by Marcel Breuer, French architect)

Matter was born in Switzerland and studied painting with Leger and Le Corbusier in the late Twenties. There he also became interested in photography. Soon he returned to Switzerland and did displays, pamphlets, and posters for the Swiss Tourist Office in Zurich. In 1935, he came to America and did photographic work with Charles Eames in California. He was also Art Director for the magazine, "California Arts and Architecture" and worked as staff photographer for Conde Nast. Today he is staff photographer for Vogue Magazine and is the publicist for Knoll Associates, having designed their catalogue.

The photo-mural which Matter has designed for the Adult Reading Room is a photomontage which consists of enlargements of various examples of ancient scripts: Greek, Roman, Hebrew, Arabic, Sanskrit, Egyptian, Chinese, et cetera. Each example of script is an ancient saying or proverb. Not only the various examples of lettering in neutral tones but also the arrangement of these samples against a white background is striking in its decorative effect. And what could be more appropriate for the decoration of a library than early examples of communication by the written word.

church and around feudalism began to disintegrate. Material prosperity from rapid growth of commerce and of industry created a wealthy leisured society of city dwellers who had time and opportunity for pursuit of secular culture. Class lines were erased, and the individual was allowed freedom to express his personality. With replacement of guild organization by the capitalistic system, economic power passed from the company to the individual. Filled with enthusiasm and curiosity, men strove to develop all their facilities and to exercise all their talents. Avid for immortal fame, they broke with tradition, and interest in Greek and in Roman antiquity was revived to provide substance for critical inspection and re-appraisal.

Until the Renaissance, physical as well as intellectual restrictions hampered both accumulation and distribution of knowledge. Writing, more precisely paleography, originated with primitive man's efforts to depict graphically the objects around him. Art forms continued to be basic tools of communication until standardization of pictographs produced the ideogram, followed by phonetic writing, first in syllables, then in alphabetic characters. Cuneiform, throughout its long history of use, never developed an alphabet. In early prehistory, the individual with a desire to communicate must have been able also to execute the necessary graphic forms. By the time of Babylonian civilization, scribes were plying the art of calligraphy in putting on stone, on marble, on clay tablets and on papyrus the thoughts of others and in making copies of existing writings. Until the end of the Middle Ages, unification of religion, philosophy and government enfolded all intellectual activities so that we are indebted to scribes of ancient times, to those of Egypt, of Greece and of Rome, and to medieval monks for the survival of much of our historical knowledge.

Art not only was the basis for the earliest communication but also continued to amplify and to extend the effectiveness of writing when it did not excell. Artists of the early Renaissance were carving and drawing readily identifiable plants and animals, but in herbals and in bestiaries of that time the illustrations were copies of purely imaginary pictures, and it is hopeless to try to identify them from descriptions by the authors.

In ancient times, schools were naturally associated with temples which were centers of all teaching. Institutions for advanced study existed during the

Greek and the Roman Empires, but the university we know today originated in the Middle Ages as another facet of the entirely new civilization developing in the western world. Among many, economic wealth and separation of church and state were prime factors involved in the favorable climate for development of academic centers in response to a revival of interest in law, in medicine and in philosophy. One of the earliest was the medical school at Salerno, established in the eleventh century. Universities were established as outgrowths of monastic schools or were developed from informal gatherings of students around great teachers. It was logical that the general organization of schools follow that of the guilds of that time; thus, the student first was an apprentice, or baccalaureus, then a master. A further period of study was required to become a doctor in more advanced studies of theology, of law and of medicine. The importance of education was being recognized and schools were fostered by privileges from a locality or from the state consisting of tax or of military service exemptions. Charters also were granted by the Pope or by the Emperor. Control of granting degrees was held by the masters' guild until in the thirteenth century when the church asserted its right to control education by requiring consent of the chancellor. Of seventy-nine universities established by 1500, a number still survive.

The return to intellectual pursuits, the development of education, and progress in arts and sciences of the Renaissance had repercussions. Legal theory from the revived study of Roman law favored state churches and absolute instead of communal ownership of property. The Protestant Reformation in the sixteenth century ended the unity of the medieval church in the West. With this social revolt, which was the culmination of many factors operating through hundreds of years, religion was recognized as an inward quality which cannot be forced, and enlightenment was substituted for constraint. In education, scholasticism characteristic of medieval philosophy dominated universities even after the Renaissance brought new studies and new methods. The Reformation adversely affected attendance and resources at first but later stimulated creation of many new universities. Even then, universities tended to follow traditional routine and looked askance at new subjects. During the low ebb of higher education in the seventeenth and eighteenth centuries, new subjects began to be cultivated by independent academies and by learned societies. The first modern universities based on academic freedom and dedicated to new studies and research (Halle, 1694 and Gottingen, 1737) precipitated modernization of institutions of higher learning throughout the world, including the United States where the work of English colleges was carried on with increasing vigor after the founding of Harvard College in 1636.

Endowed with the ability to think, to reason, man could not escape the primary urge to improve his existence, or recognition that understanding is requisite to improvement. Oversimplified, these needs are for understanding supernatural and natural phenomena. Spiritual explanations have been sought in superstition, in idolatry, in mysticism, in philosophy and in religion. In early history, all scientific exploration of nature was motivated by interest in the welfare of the individual human being. As late as the fifteenth century, universities had faculties only of theology, of the arts, of law and of medicine. Thus, the tradition of the doctor is all-inclusive, and medicine was the incubator for all the biologic sciences and, later, of new sciences formed by combinations of physical and of biologic sciences. The implications are clear. Medicine not only was required to make discoveries in all early science and to develop improved methods for further exploration but was forced also to devise whole new systems of terminology, to organize vast amounts of new knowledge, to work with artists to obtain adequate illustrations, to publish comprehensive and detailed manuscripts, and to provide for the education of following generations.

Intellectual prowess and physical achievement always go hand in hand and in the panorama of history it is seldom of major importance to know which was cause and which was effect. Here, there is little relevance in whether intellectual and cultural progress stimulated refined methods and materials of communication, or the reverse. It is enough that as written language evolved from pictograph through cuneiform and syllabic forms to alphabetic symbols, stones and clay tablets gave way to papyrus, which was replaced by paper. We can be sure that more than coincidence was involved: in the introduction of papermaking to Spain by the Arabs in the eleventh century and the spread of the art of papermaking throughout Europe in the twelfth and thirteenth centuries; in founding universities during the same centuries; in the revived interest in learning of the Renaissance, in the middle of which Gutenberg first printed from movable type (1445); and, in the vast expansion of universities and learned societies from the Reformation to the present.

In a manuscript which employs less than one word

per year of history covered, it obviously is impossible to do justice to any single factor which had significant impact on the course of man's conquest of his environment, or even to place these developments firmly in the proper perspective in relation to each other. History of milleniums is not a record of concerted, organized progress on all fronts; rather, it is the implacable, pulsating advance of floodwaters against an obstruction, with attack and recoil in search of weakness and failing this, accumulation until the deterrent is overcome by engulfment. The vastly accelerated tempo of our twentieth century rate of discovery is sustaining this fundamental truth that overall progress can proceed no further and no faster than its most limited or slowest component—the weakest link. In the last half-century, science has given man unquestioned domination of this world except for man himself. Scientific method has been carried to a high degree of refinement and results of collateral science and technology have reached an advanced state of integrated organization. Assembled knowledge has been applied in constantly increasing complexity until it has made reality of the fumblings of early alchemists and the speculative dreams of early astronomers. No one could reject the concept of communication as basic to recording, transmittal, reconciliation, organization and perpetuation of knowledge which has made all progress possible.

Today, the synchronous development of science on myriad fronts has become almost simultaneous. With victory over environment on this planet largely achieved, in principle if not yet in fact, men of science have extended their vision to probe for knowledge of the universe in which our earth is an insignificant pinhead. In this fantastically huge scheme of all nature, man seeks knowledge of all creation, including life itself. Time may reveal that in relation to the cosmos, twentieth century science still is primitive. It is certain that the snowballing rate of erosion on the mysteries of life, however facilitated by ingenious robots and electronic computors, will continue to demand increasing intellectual effectiveness also in individual and in collective application of reason. The maximum mental capabilities of any single human being, to assimilate, to organize and to evaluate, were exceeded centuries ago by the then available knowledge. The written word became the medium of intellectual intercourse and the storehouse of fact and of thought. As scientific writings continue to multiply in complexity as well as in volume, expanding requirements of research must be paralleled by corresponding criteria for publication of results. Early in the attack on space, it became clear that ultimate success is contingent upon direct on-the-spot observation by human beings, even beyond our minuscule solar system. Inanimate conquest of stars beyond the range of the 250-foot radio telescope is a tenable concept now; transport of human intelligence in a form capable of making observations and returning information a hundred or thousands of generations later is still incomprehensible. Yet this is to be the task of medical and of other biological sciences. As the tiny breach already made in this great wall is widened, medical writing, too, must always become more exacting and more discriminatory, with quantity and diversity counterbalanced by greater specificity and completeness, and with clarity through use of precise, meaningful words.

New Tuberculosis-Like Disease

The Veterans Administration, in 1960, registered 710 cases of a tuberculosis-like disease which has come to the attention of physicians in the United States during recent years.

As yet, the disease has no name more specific than "infections due to unclassified mycobacteria." The infections closely simulate tuberculosis and usually affect the lungs.

Since the prevalence of the disease in this country is unknown, the Veterans Administration undertook the task of compiling a case register from the agency's hospitals and clinics on a nationwide basis about a year ago.

So far, California has reported the highest number of cases—ninety-five. Michigan reported thirteen.

The register will be used by the Veterans Administration for evaluating treatment of these patients and developing new research approaches to the disease.

Ethics in Medical Writing

C. Howard Ross, M.D.
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THE GREEKS had a word for it—*ETHIKA*—indicating that *custom* had taken on *character*. Thus an *ideal* permeated hand-me-down *usage*.

In ancient Sanskrit, there bobs up the term—Svadhā—meaning to *set one's self*. Hence, by *one's own doing*, he could *improve* upon an expected performance in the routines of life and encompass others into his inner richness.

As a contrast, Judge Medina warns us, "It is so easy to think of oneself and let the rest of the world go hang."

Specifically, we date our basic ethics upon the moral works of Aristotle, the fact-finder and amateur evolutionist. Here the nature of the *summum bonum*, or highest good, is delineated. However, there was no sudden or explosive derring-do gush into the historical field of ethics. Earlier fragments are found, where the contemplative author pauses to reflect upon precepts of conduct.

Plato healed the gap between Socrates and Aristotle straddling a metaphysical "asses' bridge." He introduced mystical and esthetic segments to philosophy and moved his brain from the "supermarket to the college hall."

Aristotle founded literary criticism, and as philosopher, moralist and pedagogue he expended much energy upon his student, who later became Alexander the Great.

Goodness

Aristotle's Ethics contain a world of thought, influencing his immediate successors more lightly than his remote lucubrating disciples. However, as the centuries passed, controversies ebbed and flowed about the notion of *Goodness*. That seemed to be our first ethic, and bitterness gradually subsided when its halo appeared. Whether a man lived a life, dug a garden, practiced a profession, gave a speech or wrote a book, one could ask, "Was it good? Was he good? Was there well-being as the ultimate goal?" If the current philosophical hero could not perform a role in his own right, could he quote a superior on the subject of quality? Thus each generation enacted and emphasized this ethic of goodness.

Wisdom

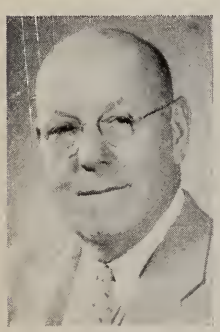
"One could not perform as an impassive sage." Soon philosophy recognized *Wisdom* as an entity of ethics. At least two classes of higher citizens loomed above the tantalizing horizon, those that were "good" —and those that were "good and wise." A tiny hamlet in its isolation did not possess sufficient exposure to the great world beyond to cultivate many wise ones. However, in the cities and cultural centers, there arose the cult of wisdom, and Ethics chalked up number two on the score.

Knowledge

As schools developed, and teachers disseminated thought-provoking principles, *Knowledge* entered as the third great ethic. If one were going to open his mouth to teach, or to take a fervent breath to preach, or to screw his courage to the written page, it was well that he possessed some organized idea of what he was expounding. If wisdom were the only ethic, then the lack of wisdom yielded evil. But if wisdom were a broad ethic, then it could encompass the spectrum of philsopohy and delineate between good and evil, with knowledge tilting the balance.

Hippocrates

Man or men or partial myth or combination of all, Hippocrates was a contemporary of Plato and a precursor of Aristotle. He has served as "Father of Medicine" these many centuries. Much that he wrote,



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or his students concocted, plus samples of fairly ethical writings of unknowns—were "dumped" into the Hippocratic Collection, only to be deleted or added to as the centuries passed. To many medical writers, the controversial figure of Hippocrates is a symbol of surety and truth, since he gave us an oath of guild ethics and eliminated the responsibility of the physician in employing the medical incantation.

Thus he became, by tradition, a constant element above the thunder of scholastic warfare. According to Celsus, he was the first one "to separate medicine from philosophy." Superstition was eliminated by Hippocrates from the medical literature of his times.

Hippocrates regarded his fellow practitioners as his brothers and looked upon a medical apprentice as his son. In his writings, he carefully attempts to delineate symptoms and findings before hazarding a diagnosis. On many occasions he hints a prophesy of our most modern ethic, "*good medical care.*"

Hippocrates and his group amaze me at the clarity of their style. While brevity is preached—with so much to say—it is not practiced, but obscurity and confusion are far from the aims demonstrated.

The Spirit

When the Universal Church spread its principle of *Service to Others* throughout Europe and the Middle East, the confirmation of an old ethic became a new ideal. I hold no ethical grudge against any religion. Probably my limitations do not encompass their mechanics, like Paré; but I rejoice in the "*Spirit*" of the Judaeo—Christian—Islamic Faiths and Oriental philosophies. This spirit has crept into our modern medical writings and pervades our aims. An agnostic physician may not know where to place his ecclesiastical vote, but the spirit of service to others, infiltrating his writings and acts—indoctrinates him within the confines of ethics and places a "well-done" upon his contributions.

Definition

So far, then, I would like to define *Ethics* as the performance of *Morality*; and morality to me is the practice of the *Golden Rule*, with "a modern shot of vitamins." There is a positivity to this definition. You will recall Paré's ethics as a series of negations:

"I will not return to my mother's womb."
"I will not fight in battle."
"I will never desert the king."
"I will not accept the mechanics of the church, but I will accept its Spirit."

There you have it. The negations ended, but the positive Spirit began to assert itself.

Dicta

Galen's ethics of the second century, A.D., were so thunderous that they lasted for thirteen and a half centuries. He was a perfectionist and a great medical egoist. He actually felt that professional and lay communities required no other authority than himself. This domineering technique is ethically distasteful today.

The man that gave Galen an historical kick in the pants was Phillipus Aurelius Theophrastus Bombastus von Hohenheim, known to us as Paracelsus. He shouted backwards at Galen and the great Iranian physician of the eleventh century, Avicenna, "I shall not follow you. Me—me—you will follow!" This was a sort of retroactive reversal of ethics.

He burned the Latin works of Galen in the public square and then attempted to create scientific and ethical terms in the Germanic medium.

In addressing the student-faculty assembly at the University of Basel, Dr. von Hohenheim aimed his remarks at his confrères disdainfully, "There is more brain power in my beard than in all of you."

One concludes that he did not go over well. He confused "medical exposure" with "medical honors." From safe observation, he could concoct a theory of "thin fantasy."

Dicta of gross or offensive nature do not belong in ethical medical writing.

An author should not "wear blinders" against new scientific adventure.

The Place of the Theory

William Harvey pronounced his theory of the true circle of the blood in 1616. He assumed the existence of capillaries without ever having experienced their retinal image. In fact, his theory was in advance of Galileo's microscope by eight years. The ethical publication of "The Circulation of the Blood" did not occur until 1628. That year was the birth date of Malpighi, who later witnessed the lowly corpuscles whizzing in the capillary beds of the obedient frog's lung, proving Harvey's dissertation.

Theories, based on observation, certainly have a place in ethical medical writing. This may also be true of theories based on all facts but one. Here a bridge is created, linking the "known of today to the unknown of tomorrow." Later generations, however, may have to be born, then rise and shine, to prove the intent and to confirm the ethics.

Harvey taught us that we must not be distant and aloof from our chosen subject.

Experimentation and Reporting

The recording of scientific experimentation certainly places itself high in the standards of ethical medical writing. I am thinking fondly of the Michigan backwoods gastro-physiologist — Beaumont. He "shook the world by its gastric juice" in 1825, when he first presented the digestive sequences of Alexis St. Martin's fistulous stomach.

Many observers before Beaumont and thousands after him have entered into medical writing. Here Ochsner warns us against statistics taking on a rosier hue than warranted.

Somewhere, a picture must become clear, and a hesitant conclusion awaits being drawn. If neither occurs, ethics disappear because the spirit has died.

Modern tabulations that are so profuse that they become obscure, dodge the dictates of ethics. If the writer blooms into a lecturer, and the fine print on the devilish slide cannot be read by an intelligent audience, he has discarded his pedagogy and trampled upon his ethics.

When the written word is translated into the hoped-for audible word, but alas is not heard or understood through the limitation of expression or by microphone failure, the medical spirit has withered. Ethics have faltered; dullness and monotony have taken hold.

It is ethically important that custodians of a lecture hall be as alert in presenting a broadcast as an editor is in "slicking up" an article for publication in a medical journal. When the speaker fails to communicate in the language of his audience, he is ethically invited to attend a class in public speaking and to become "hep" to the demands of medical communication. A lecturer who pounds and shouts at his manuscript does not improve it, but fails to recognize his audience and thus misses the ethical boat entirely.

A speaker expecting vibrant attention from his listeners, is invited to "return the compliment in advance."

Plagiarism

In at least five sources, I have observed a repeated thought that runs something like this, "Originality is subconscious plagiarism."

The Latin word *plagium* refers to kidnapping. I would like to dwell a thoughtful moment upon the subject of kidnapping ideas, expressions, entire articles—without regard to the dainties of recognition.

Since we are what our ancestors, our environment and the inner self have created, it becomes increasingly difficult to stand alone as a substantial Niagara of power. Emerson hinted that no pure originality exists. Nonetheless, quotation marks are not architecturally difficult to manipulate, and the jealous writer may become the generous and well-read producer by their employment.

Acknowledgment, graciously done, to source material, to inspirations, and to techniques, serves as an ethical instrument in medical writing. It not only places the author in happy perspective to the reader and to the original creator, but "reflects his experience upon the mirror of others."

When an author quotes himself from a former observation, no one will accuse him of self-plagiarism. He at least should possess a corner on his market slightly superior to that of the reader, who is seeking scientific adventure by scanning the first page.

Copyright

Let us consider a "loan of words" that has reached several lines from an article protected by copyright. It is now high time that correspondence be initiated with the writer, out of courtesy, and with the publisher, out of legality, to secure written permission to quote. I realize that scientific writing is done for the general welfare of the human race, and a judge plus a jury of peers may think twice before naming a budding genius as culprit. Let us not be so blissfully hopeful that we become regretful, however.

If we quote from a distinguished source, let us not garble the message. What is within the "lifted word" should shine in its pristine purity. Thus, rough scratch notes made by a slam-bang researcher in his off moments at the library, cannot be blown up later by his own bicycle pump and then called original source material.

These same rules of courtesy and copyright apply to charts, to graphs, to photographs and to technical illustrations that one may borrow to complete or to emphasize an article.

The patient himself must be consulted if his identifying photograph is to accompany a contribution, whether its introduction is original or secondary.

A confession of original "quip or quote" is like returning a borrowed lawn mower to the proper though anxious owner. Medical writing ascends to a level of dedicated pedagogy, but it must not in its sublimity become the rumbling cause of a snarl.

Summary

In commenting on "Ethics in Medical Writing," I have leaned heavily upon the crutch of the past.

Word sources from ancient Greek, Latin, and Sanskrit have been shaken out of their comfortable niches and reactivated.

Tribute is paid to the philosophies of Socrates, Plato, and Aristotle. Their historical disagreements have yielded to us workable truths.

Each individual ethic as it developed in history is enshrined within our modern medical writings. I have developed and make my bow to *Goodness, Wisdom, Knowledge, Hippocratic Truth, The Spirit, Service, Morality, The Theory, Experimentation, Reporting* and, lastly, *Good Medical Care.*

I have urged that *dicta* of gross or offensive nature be avoided in medical writing. The author must be in ethical charge of his creative forces.

When the written word becomes audible, the medical speaker is ethically bound not only to be *heard* but *understood* by his audience. Shouting at a manuscript does not improve it. I make my plea that the assembled physicians rank equally with the manuscript and be given vibrant attention by direct address.

Plagiarism, the rules of recognition and copyright have been analyzed and discussed.

Medical writing ascends to the level of dedicated pedagogy.

(List of references for this paper will be found in the amalgamated list of references on medical writing for all papers in this special issue of The Journal *on page 234.)*

Quantitative Cytologic Study of Anhydrous Mass in Regenerating Liver

In the present study, we measured anhydrous mass of liver cells following partial hepatectomy. Hepatectomized rats were sacrified daily for six days and later intervals. Liver was perfused with cold physiological saline containing versene and suspensions of liver cells made, mounted in glycerol and examined with a Cooke-Dyson interferometer microscope. Cytoplasmic mass was calculated by formula: $M=\Delta_m A/\chi$, where M is total anhydrous mass, Δ_m optical path difference, A area and χ proportionality factor. Our calculated χ was 0.0663 $cm^3\ gm^{-1}$ for fixed glycerol mounted liver cells. We found mean normal value of anhydrous mass in single liver cells to be 14.16 x 10^{-10} gm. On first and second day after hepatectomy, there was a sharp increase in mass to 16.88 and 16.46 with rapid drop on third and fourth day to 13.72 and 11.49, followed by gradual increase in mass. Decrease in mass after second day corresponds in time to peak of mitosis and cell division. Sham operated animals on first and fourth day gave liver cell mass of 14.20 and 14.23 which is same as normal. As far as we know, this is the first time cytoplasmic mass of liver cells has been measured in normal and pathologic conditions. The significance of findings in relation to liver pathology will be discussed.—Bjarne Pearson and Fred Grose, Wayne State University and Detroit Institute of Cancer Research. Paper presented before Detroit Physiological Society, December 15, 1960.

Suggestions for the Author of a Medical Paper

S. E. Gould, M.D.
Eloise, Michigan

MOST physicians of repute become known by virtue of their writings. In the interest of improving the quality of medical writing, the following suggestions are offered for consideration of the author of a medical paper.

Subject

The paper should have some special interest for the reader, as in reporting of a new, unusual, or significant observation. It should be documented by presentation of pertinent data and illustrative material, and by references to cited authors. The writing should be concise and easily understandable. After the author has outlined his project, he must consult the pertinent literature to learn what is already known concerning the subject. The author should report his data and opinions in such a manner that the reader is free to judge the merits of the observations, interpretations and conclusions.

Style

The manuscript should conform to the styling of the journal to which the author submits his paper, including: format; listing of names of authors, their degrees and academic or hospital positions, department from which the paper is submitted, and source of financial support or sponsorship of the work; length of manuscript; use, typing and position of headings and subheadings; form of summary; arrangement and amount of tabular and illustrative material; use of footnotes and acknowledgments; and details of listing of references. The periodical should be consulted for its stated editorial policy and requirements.

Title

In general, the title should not exceed eleven words. If necessary, a subtitle may be used. The title (and subtitle) should indicate the nature of the report and subjects to be indexed. Running headline (condensed title for top of right-hand printed pages) should be furnished, consisting of not over thirty-five letters, each space between words being counted as a letter.

Typing

The manuscript should be neatly typed, double-spaced on white bond paper, measuring 11 by 8½ inches, of good but not extra heavy or expensive quality. *All* material should be double-spaced, including title sheet, quoted material, tables, legends, and references. The left-hand margin should be at least 1½ inches wide, others at least 1 inch wide. Use of footnotes should be avoided; if footnotes are essential and permitted, these should be arranged numerically and typed double-spaced on a separate sheet. A carbon copy of the final draft should be retained by the author for future reference and for checking against galley proof. A clean, fresh, original copy should be submitted to the editor. The pages should be consecutively numbered at the center of the top and not fastened with clips or staples. The manuscript should show evidence of care in use of English, spelling and punctuation, and in organization of material presented.

Quotations

One should not copy another author's quotation or interpretation of work of a third author, but should consult the original source to check the accuracy of the quotation or interpretation.



The Author
S. E. GOULD
M.D.

Dr. Gould is Pathologist, Wayne County General Hospital, Eloise, Michigan, Professor of Pathology, Wayne State University College of Medicine, Detroit, and formerly Editor-in-chief of the *American Journal of Clinical Pathology*.

Illustrations

Illustrations are generally of two types: pen-and-ink drawings, reproduced by the line engraving process, and photographs of any material containing shading, reproduced by the halftone process. Every figure should be identified by writing lightly in pencil or by pasting a label on the reverse side, giving the name of the author, figure number, abbreviated legend, magnification (in the case of a photograph or photomicrograph), and indicating the top of the figure. One should not attach a paper clip to illustrative material or write heavily on the reverse side, for it might damage the face of the illustration. All drawings should be made with India ink, preferably on tracing vellum, white drawing paper, or white drawing board of good quality. If coordinated paper is used, this should be blue-lined so that cross-sectioned lines will not reproduce in the printed figure. Lettering should be of professional quality and large enough to be read easily after reduction. In general, legends should not be lettered or included in the body of the chart but should be typewritten. Charts should be attractive in appearance and easy to understand.

Photographs, photomicrographs and other illustrative material such as x-ray films should be easily understood, pertinent, instructive, and of excellent technical quality. They should show detail and have good contrast with the backgrounds. Photographs should be glossy and unmounted. A recommended size of photographs is 7 by 5 inches. Illustrations should be larger than the size desired in the printed article. Legends should be fully explanatory and typed double-spaced on a separate sheet of paper. A photograph in which an individual can be identified requires the permission of that person for publication; if permission is not obtained, the eyes should be covered by a circular or rectangular piece of white paper.

References

As a rule, the care with which the references have been prepared is a good indication of the quality of the manuscript. Misspelling of an author's name or incorrect designation of his initials constitutes a serious error. In reviewing the literature, sources of references in addition to *Quarterly Cumulative Index Medicus* and *Current List of Medical Literature* should be consulted. These may include the *Index Catalogue of the Library of the Surgeon General's Office, Biological Abstracts, Excerpta Medica,* cumulative indexes such as those published in *Surgery, Gynecology and Obstetrics,* year books, and recent volumes of periodicals (in English and foreign languages) devoted to the special division of medicine that embraces the subject of the paper. No reference should be listed unless it is cited in the paper.

In preparing the list of references, consult original sources for exact spelling of names, titles, periodicals, volume, pages, year. Abbreviations of journals should generally correspond to usage in *Quarterly Cumulative Index Medicus.* In listing references to a book, give the name, title, edition number, city of publication, name of publisher, year, page or pages cited and total number of pages of book. In listing reference to a paper published in a foreign language, give full foreign title if this can be written in English characters, followed by English translation in parentheses.

Copyright Regulations

In quoting verbatim, copyright regulations should be observed. For most material, it is permissible to quote fifty to 100 words or two or three sentences without specific authorization. Permission to reproduce copyrighted material, including figures and tables, must be obtained from the copyright owner. As a matter of courtesy, permission should also be obtained from the author and the editor of the publication. Acknowledgment should be made in the printed manuscript to the author and the copyright owner that permission has been granted for reproduction of the material borrowed.

Some Specific Usages

Measurements

Term to be Avoided	*Correct or Preferred Term*
cc.	ml. (1 ml.=1.000027 **cc.**)
6¼ cm. or 2.5 inches	6.25 cm. or 2½ in.
size of a lemon	(Give measurements in cm.)
urea in blood, 15 mg. per cent	15 mg. urea *per 100 ml. blood*

Word or Term

Term to be Avoided	*Correct or Preferred Term*
2,697 individuals	2,697 persons (or patients)
X-rays revealed no pathology.	X-ray *films* revealed *no evidence of disease.*
Patient was esophagoscoped (electrocardiographed, x-rayed).	Patient had an *esophagoscopic* (or other) *examination.*
No malignancy was present.	No evidence of malignancy (or no malignant tumor) . . .
He had no temperature.	He had no *fever.*
this case of cancer	this *patient* with cancer
right neck (chest, abdomen)	right *side* of neck (chest, abdomen)
to biopsy the liver	to take tissue from the liver *for biopsy*

Word or Term (continued)

Term to be Avoided	*Correct or Preferred Term*
The patient was biopsied.	Tissue was taken for biopsy.
nouns as adjectives: Tumor Registry Committee Progress Report	Report of Progress of Committee for Registry of Tumors
adjectives as nouns: diabetic, syphilitic, humans, thyroid, prostate	patient with diabetes (or syphilis), human beings, thyroid gland, prostate gland
Babinski	Babinski's sign (or reflex)
a 6 x 7 cm. mass	a mass, 6 by 7 cm.
the glucose content in the blood	the *concentration* of glucose in the blood
brownish red	brown-red
This data is . . .	*These* data *are* . . .
The patient was considered to have . . .	It was thought (or believed) that the patient had . . .
The condition was considered to be . . .	The condition was regarded as (or believed to be)
lymph gland	lymph node
this *female*	woman (or girl)
pathological, physiological	pathologic, physiologic
This condition was *due to* . . .	. . . *caused by*, or *the result of*
due to this condition	*owning* to this condition
cerebrovascular accident	Specify whether cerebral thrombosis, hemorrhage or embolism.
Patient (or lesion) was *tubercular*	tuberculous
too frequent use of relative pronoun *which*	*that.* (*That* is defining or restrictive, *which* is nondefining.)
too frequent use of *marked*	severe, great, much
too frequent use of *this* as pronoun	Specify noun.
The lesion *shows* . . .	. . . is, consists of, has, is characterized by
there was	(Use only occasionally.)
decubitus ulcer	decubital ulcer
The hematocrit was 44 per cent.	. . . hematocrit *reading* . . . (Hematocrit is an instrument.)
to differentiate these tumors	to distinguish . . .
these *subjects*	patients or persons
excessive use of *very*	delete *very*
auricle	atrium
papanized, trypsinized cells	papain-treated, trypsin-treated
because of the fact that	because

Spelling

Term to be Avoided	*Correct or Preferred Term*
10 ml. (at beginning of sentence)	Ten milliliters . . .
Bence-Jones protein	Bence Jones protein
Wasserman test	Wassermann test
Hoffman reflex	Hoffmann's sign (or reflex)
epididymes (as plural of epididymis)	epididymides
Ascheim-Zondek	Aschheim-Zondek
gastro-intestinal	gastrointestinal
leucocyte	leukocyte
Endamoeba Histolytica	*Endamoeba histolytica* (italics)
8 weeks incubation	8 weeks' incubation

General Comments

It is assumed that the work to be reported is accurate and will stand the test of checking by others. If this is not true, it is a mistake to submit the work for publication. The author should be as meticulous in the preparation of his manuscript as it is assumed he has been in the conduct of the clinical or laboratory work that he wishes to report.

A paper should be revised repeatedly before the author can regard it as suitable for publication. The transcript should be written in as few words as are consistent with good usage. With each condensation of the essential data and interpretation, the paper will usually gain in readability and effectiveness. Before submitting the paper for publication, it is suggested that the author send it to one or more experts in the field for their frank comments and criticisms. He may also wish to ask a qualified person to check the rhetoric. If there is any secret to good medical writing, it lies in repeated review and reworking of the paper.

When the final draft has been completed, the author should be able to answer the following questions affirmatively: Does my paper contain something new or significant? Is my presentation interesting, easily understood and well written? Is this a creditable report? Do I believe that the editor would be eager to publish this paper? The author should remember that the editor occupies a position of trust in presenting to his readers the best material available to him. The author must, therefore, solicit the interest of the editor and strive to satisfy his requirements.

To be jealous of the woman one loves is to give evidence of a strange lack of reasoning power. Either we are loved, or we are not; and, in either case, jealousy is a passion which is of no use to mankind; it cannot be accounted for any more than fear; it may be that jealousy is fear in love. A jealous man does not doubt his wife, he doubts himself. —"The Physiology of Marriage" by HONORE DE BALZAC.

The Scientific Paper

S. Howard Bartley
East Lansing, Michigan

AN ARTICLE appearing in a scientific journal should differ considerably from one appearing in other journals or magazines. Although this is generally taken for granted, the characteristics of a proper science article are not always clearly understood.

The characteristics to be discussed in the present article will have as much or more to do with the scientific paper's content as its format. Formats vary considerably from journal to journal, and nothing rigid can be said about them. That the paper's intellectual content rather than format is of prime importance is greatly emphasized in a lengthy paper written a few years ago by Hans Selye, entitled, "How Not to Write a Medical Paper." The paper was almost entirely devoted to the discussion of *seven traps of thinking*, or the common fallacies in scientific research. The moral of Selye's paper was that only if proper thinking and experimentation precede the writing of the paper will it have a chance of being worthwhile.

Assenting to Selye's principle and drawing upon my own experience and my own outlook on science, I shall indicate the prime factors to be considered in writing a scientific paper.

Significant Intent and Content

Both content and intent of the paper should be *significant* for science. Science is a major human endeavor consisting in discovering and in organizing knowledge and in developing an understanding of Nature. It consists in methods for obtaining such knowledge and development of such understanding, including an attitude of mind so pervasive and distinctive as to be called a way of life. Science does not stem from sporadic forays or gallops into experimentation as weekend endeavors, or attempts to satisfy one's own superficial and fleeting curiosities. In a sense, it is at best a way of life, the result of a kind of perennial way of looking at things practiced by a wide group of men who are willing to be as different from other persons as may be required. Since considerable indefiniteness is possible in common views of science, what is written as a scientific paper may easily be far from it. Scientific writing is more than mere reporting of facts. Facts are endless in number, so selection among them must be exercised in light of some principle or purpose. The time has passed when the reporting of a few interesting facts justifies space in a scientific journal.

From Michigan State University, East Lansing.

Exposition, not Narration

The scientific paper, of course, should be expository, and not narrative and casual in form.

Report and Theory

The scientific paper may be either *reportorial* or *theoretical* in emphasis. From what was said about the significance of scientific papers, it can be inferred that the paper is not a mere reporting of information. Some theoretical significance must always be evidenced. Scientific endeavors have continued long enough by now to be organized. There is some background for almost every area of research or interest in which one might become involved. Few areas of intellectual concern are utterly unique and unrelated to some field of present knowledge.

Much of science consists in *seeing connections* between facts or phenomena, in *interpretations* so as to interrelate the maximum number of phenomena, in being able to *anticipate* what will happen in new kinds of situations. Although much is made of prediction, and whereas it has tremendous practical utility, it is not prediction for its own sake that represents the central ideas of science, but prediction as anticipation of new orders of understanding. This is what Selye calls discovery. Hence, theoretical papers have a significant place in science journals. Although there ought to be some speculation in all papers, certain papers wholly devoted to theory are highly appropriate.

Inclusion of Reference

What has just been said leads to a more specific statement regarding orientation of the paper. It should refer specifically to the work of others in the field and give evidence that the writer is aware of what is known, although he may not be able to confirm cer-

tain previous findings. He may be able to show that a new interpretation must be put upon the facts in the particular area under consideration. In this connection, the writer should make it clear why he did what he did, and if conflicting results have been obtained, he should endeavor to discover and to disclose the reason therefor.

Evidence of Sophistication

Another way of stating the qualities needed in a scientific paper is to say that it should represent the highest possible sophistication in the particular field. The paper is, from the broadest standpoint, primarily an effort to promote science, rather than to promote the individual. This can only be true to any material degree when sophistication is involved. Sophistication is at its highest only when relevancies are being dealt with both in the research involved and in the reporting of it. The novice does not know, on his own, what is relevant and what is not. He does not know what is crucial to a better understanding; hence, his laboratory efforts may be to little point without his realization of the fact.

Conciseness

The scientific paper should be concise and closely written. In narration, fewness of words is not always a virtue. What may seem like redundancy often is contributory. In exposition, this is not the case, for it is not mere impressions that are being given the reader. Overdoing detail obscures essentials. In exposition, clear workable understandings are to be transmitted. Conciseness is urged for the readers' sake, but there is another reason for it. With the many scientific and technical journals published these days, there is not room for nearly all the articles that are submitted. The more concise, the less waste of space, the more articles can be accepted.

Simplicity and Unity

No single paper should be intended to make many points. The choosing of a unit of work or material to publish is more than an incidental matter. If an article reports only a small portion of one's recent work in a given area, thus requiring several articles to report all of it, one might be accused of making such a choice in order to enhance one's list of publications. If one were to go to the other extreme, the total report might either be excessively long, or so superficial as to be of greatly reduced value. Some elements of work tend naturally to form units and when so, there is little or no problem: break the work into reports according to natural units. There are other times, however, when the division of material may seem arbitrary. It would seem then that one should assemble his material in light of the prime points to be made, the reader group to be dealt with, and the length of articles allowed in journals reaching one's chosen reader groups. Varied problems actually dealt with in a single investigation do not always belong together in the same written paper. Ingredients should be assembled meaningfully and to some purpose. Things should be kept as simple as possible.

Appropriateness of Journal

The article should be placed in the *appropriate journal*, or, to put the matter the other way around, the paper should be *appropriately formed* for the journal chosen. There are times when the limitation lies in the availability of journals. If one's material is to be published anywhere, it may be necessary to publish it in one of a limited number of journals. That being the case, one starts from this fact and writes his article to fit the chosen journal. Although it is the editor's prerogative to say which articles do and which do not belong in his journal, choosing of the appropriate journal is one of the author's responsibilities.

Knowledge of Editorial Policies

Every scientific journal observes certain forms and follows certain editorial policies. Its format involves policies of style, such as the use of passive or active voice, subdivision of the article into problem, apparatus, procedure, results, and discussion sections. Some journals require an abstract to be placed at the beginning of the article. Others require the final section of the article to be the summary. Some journals require submission of manuscripts in triplicate, although many require only two copies, and some ask only for the original copy. Some ask that the manuscript be triple-spaced rather than double-spaced. One of the policies in which there is considerable but diminishing variation concerns the form used for citations and reference lists. Some journals use citations in footnotes which, of course, are generally to be typed on pages separate from the text of the manuscript for the typesetter's convenience.

Choice of Verbal Style

In writing any paper, the verbal style is open to considerable variation. For example, if one is writing for a homogeneous audience, and one which is well informed in the area of one's work, much can be

taken for granted, and terms which might otherwise need to be defined can be used without such explanation. While there are hundreds or thousands of journals, many of them do not have fully homogeneous groups of readers. Articles published in these cover a variety of interests. This being the case, some papers are read by some of the journal's readers, and others are read by still other persons. Facing this fact, the question of how broad a group of readers one wishes, or can expect, to reach is immediately relevant. It might well be concluded that usually an article should be written to reach as many readers of the chosen journal as possible. This means that, in spite of all that has been written about brevity and conciseness, the author must ask himself whether readers will be familiar or unfamiliar with prime words or terms he is inclined to use. Thus, in writing the paper in words best understandable to a broad group of readers, he must define more terms than when writing only to associates. The editor could be expected to judge, to criticize, and to accept or to reject a manuscript on the basis of whether it reaches only a restricted portion of the journal's readers. If the author is aware of this problem he can be more effective, and, at the same time, avoid editorial criticism.

Finally, it should be emphasized that the paper should lack all traces of having been hurriedly written. It should be the author's reasonable best, rather than his first or second draft. When the editor finds that the exposition is garbled and that points to be made are not well thought out, it is certain that the paper should never have been submitted in that form. These remarks issue from my own experience in having read many papers submitted to certain scientific journals for the determination of acceptance or rejection.

Correspondence Between Title and Content

As a reader of scientific journals, but particularly as an associate editor, I find papers whose titles and content do not well tally. It is common to see titles such as the following: "The crucial influence of A upon B," and then to discover that the article shows that A has no influence on B. Obviously, the title might better have been: "The lack of influence of A upon B." A number of possibilities of mis-titling articles occur. Articles are catalogued in terms of their titles. Hence, if one is aware of this, he may influence how his article will be indexed and catalogued in various lists and files. This helps to make a real difference between those who will discover that the article has been written and those who can make use of it.

Illustrations and Tables

These two forms of presenting data serve different purposes. If it is the purpose of the author to show broad relationships in a graphic and understandable way, graphs serve. On the other hand, if it is his intent to provide concrete quantitative data that are quickly obtainable by readers for their use, tables are necessary. This is because no graph that has been reduced in size to fit a publication is quite as accurate as a table of numbers, nor is it as convenient for obtaining numerical information. Don't crowd graphs; put some information in the legends.

Plans of Publication

For fear that some authors are not well aware that some scientific journals provide two plans of publication, this fact is here pointed out. In addition to the regular plan, in which each author takes his turn in the calendar of publication (first article accepted being first to appear), there is a plan providing "immediate publication." This plan is workable because the author pays for the extra costs or the total costs of production of his article at a stated page rate. As soon as his article is accepted, processing can begin. Reprints of this article then are soon available and the article is added to those already printed, and as soon as enough pages have accumulated, the articles are bound as a volume. This means that such journals may issue a variable number of volumes per year, depending upon the number and the length of papers accepted. Other journals vary in the number of pages per issue, depending upon the number of articles accepted, the variable factor being the number of immediate-publication articles accepted. Publication lag in some scientific journals has come to be, or has long been, quite great, reaching as much as two years. Authors must be aware of this lag for the journal selected, particularly when timing of the article's publication is of crucial importance. Again, if a series of articles is to be published, it is well to have the several separate papers appear in proper order.

Summary

The writing of a scientific paper consists not only in verbally reporting a set of facts, but also in choosing what is appropriate to write about. The whole process begins when one decides what to investigate in the first place.

Once an article has significant material to convey, there are several rules to follow, some of which are different from those used in other forms of writing. The present article points these out.

Preparation of the Clinical Report

Russell N. DeJong, M.D.
Ann Arbor, Michigan

THE CASE REPORT has been called the foundation of clinical medical literature. It occupies a singular but important place in scientific writing. Much of our current medical knowledge is founded upon information which was originally presented in the form of the clinical description of a single case or of a small group of cases. In many instances such a report has served as the stimulus to further investigation and amplification, and thus has brought about the broadening of our scientific horizons.

The preparation of a satisfactory case report, however, is not simple, and may take as much thought and judgment as the writing of a medical essay or the describing of the results of extensive research. Many of the clinical reports which are submitted for publication have imperfections and deficiencies which make it necessary for the discriminating editor to reject them. Often such a report is the work of a novice in medical writing and is poorly prepared. As such, it abounds in medical jargon and poor diction, and may contain irrelevant details, unimportant and negative observations, confusing abberviations, and ambiguous statements. Such a poorly written report adds little that is of value to medical literature.

Only occasionally is a single case worth reporting. In general, it should be a novel and individual condition, which, as ascertained through a fairly detailed review of the existing literature, has not been previously presented. In this day and age it is exceedingly rare to find a condition which has not been recorded and discussed before, and anyone who feels that he has stumbled upon something novel or obscure should investigate prior publications thoroughly before claiming originality or hurrying into print. There are, however, situations in which a single case or a group of cases may be reported even though there is current literature on the subject. This may be to call attention to unrecognized manifestations of the condition, to remind a journal's readers of certain aspects that may cause diagnostic confusion, or to add to the knowledge of its treatment. A well written clinical report, made with discrimination and judgment, is always welcomed both by editor and by reader.

From the Department of Neurology, University of Michigan Medical School.

The clinical report must be scientifically accurate and its grammar and diction should be clear and lucid. The author should revise and polish it until it compares favorably, both in technical and in literary aspects, with more detailed and extensive medical essays and reviews. It should never be copied directly from the original records that were hastily jotted down at the time various events occurred.

Usually, the report begins with a brief review of the disease or clinical syndrome under consideration, or of closely related conditions if the syndrome is unique, and a statement telling why the author believes it is desirable to report the case. References to existing literature on this or similar conditions may be included here, but these should be limited to those of real significance and should be accurate and follow the style of *Index Medicus*. If a comprehensive review has been published fairly recently, it is often sufficient to cite this, adding only the more recent references or those which the author desires particularly to emphasize.

The case report itself may follow next. It should be clearly written with only necessary data included. Separate paragraphs may be devoted to the patient's history, family history, physical examination, laboratory investigations, course, results, and, if available, the postmortem observations. Use of the patient's initials or of hospital case number is undesirable. Negative observations, redundant statements, and unnecessary material should be omitted. The author should use short, accepted, simple words. There is no place for medical slang or colloquialisms in any scientific article. Solecisms, vague and inaccurate terms, and circumlocutions should be avoided. Ab-

The Author

RUSSELL N. DeJONG, M.D.



stract words should not be used as concrete ones, and nouns should not be used as verbs or adjectives. Only standard abbreviations should be used.

In citing a few common errors, it is important to bear in mind that the practicing physician often uses many terms and expressions which are ungrammatical and can only be termed medical jargon or colloquialisms. These may be useful in brief, informal discussions and in hurriedly written notes which are often a part of a patient's record, but they are inappropriate in scientific publications. Such phrases as "acute abdomen" and "right heart" have no place in medical literature. A case is an instance of disease, whereas a patient is a human being afflicted with disease. Operate, in medical usage, is an intransitive verb and we cannot "operate a patient." Surgery is an abstract term and should not be used to indicate a surgical procedure. Nor should a noun be used as a verb, as in "to staff a patient." Adjectives describing disease states and pathologic conditions themselves should not be used to refer to individuals so afflicted, as in "two leukemics" or "three meningiomas were admitted to the hospital." It is better to use terms such as girl or woman and boy or man rather than male and female. Trite and overworked phrases should be avoided and simplicity of expression should be sought. If the patient died, one should say so, and not seek for euphemisms such as "came to exitus," "had fatal termination," or "his respirations ceased." Emponyms should be used only if they are more widely accepted than corresponding anatomic and pathologic terms. Reports of consultants and those from clinical and pathologic laboratories are often attached to a patient's record; these are not written for publication and should not be incorporated into a medical article verbatim. If information from them is to be included, the original report should be re-written and woven into the fabric of the paper. Abbreviations are often confusing, and have different interpretations at various locations and to different specialists. P.A., for instance, may mean pernicious anemia to the internist, paralysis agitans to the neurologist, or postero-anterior to the roentgenologist. The abbreviation EEG, widely used today, has been used to refer to the noun for the instrument employed, electroencephalograph, to the noun for the recording, electroencephalogram, and to the descriptive adjective, electroencephalographic.

Well-selected illustrations may add to the value of the report and bring out or emphasize factors that cannot be described as adequately by the written word. They should be used, however, only if they constitute a contribution to the report, and then should be clear, reproducible, and accurately labeled. Legends should be descriptive but brief. Charts and tables may also present material more clearly and more vividly than the text itself; if such is the case, they may be incorporated into the report. However, they should be few, simple, properly captioned, and contain no confusing details.

The description of the case or cases may be followed by discussion. In this, the author can synthesize, correlate, and emphasize important and salient features of the cases described. Herein, they can be compared or contrasted with previously reported cases or with similar cases from which the present ones must be differentiated. Outstanding manifestations of the syndrome should be brought out, and essential clinical, diagnostic, clinical pathologic and pathologic features stressed.

The discussion is often followed by a brief summary and conclusions, although on many occasions neither of these may be necessary for a case report. Statements made in the introductory paragraphs should not be repeated in the summary, but the summary should briefly recapitulate observations made, conclusions presented, facts that can be derived, and deductions arrived at from evidence presented in the paper. To write a good summary is no easy task; many revisions may be necessary if it is to serve the purpose for which it is intended. However, a summary, if clear and concise, is usually appreciated by the busy reader. A few brief, well-worded conclusions may follow the summary. These are more effective if numbered, but if numbered they should be coordinate in structure and in presentation. Conclusions should be used only to clarify and to condense salient facts of and deductions from the presentation and should not be mere repetition of discussion and summary.

To conclude this short consideration of one of the important aspects of medical writing, the author would like to stress that, due to the need for brevity, only the major aspects of the clinical report have been mentioned. Anyone who wishes to prepare a medical manuscript of any type, including a clinical report, should have available, and be familiar with, a few of the outstanding references that have been prepared for medical authors. These include, among others, "Medical Writing" by Dr. Morris Fishbein, "Guide to Medical Writing" by Dr. Henry A. Davidson, "Rx for Medical Writing" by Dr. Edwin P. Jordan and Willard C. Shepard, and "The Physician-Writer's Book" by Dr. Richard M. Hewitt.

The Role of the Librarian in Intern and Resident Writing

Chloe S. Brewer, A.B.
Detroit, Michigan

TWO IMPORTANT functions of the hospital librarian are to aid the resident who is writing a paper by helping him to find source material and to prepare a formal bibliography. If it is a statistical paper, he should have statistics reported from other hospitals of comparable size and standing. Should this paper be an essay type, he should know what other persons have said on the same subject. If he is presenting a case report, he should see how many cases have appeared in the literature, how they were managed and their ultimate outcome.

The interested hospital librarian wants to see the literary neophyte write a good paper, with properly constructed sentences, variety of vocabulary and correct punctuation. The hardest thing to do is to get him started—"just put something down on paper," we say to him. The first paragraph is always the most troublesome, as it is to the majority of authors.

After the first roughdraft is made, he should read it to the librarian. She can make constructive suggestions; and the author, himself, may see many places where it could be improved. If he has been too didactic while writing on a controversial subject, the librarian will point out to him that he must document his paper. References from notable physicians who are of the same opinion should be accurately cited. He may cite references contrary to his stand and endeavor to refute them; or if he is broad-minded and can conscientiously do so, he may concede the opposing opinion the possibility of also being right.

There are many colloquialisms used in medical writing that could be eliminated without making the author's style stilted or dull. All of us know that the clear, simple style is the most readable. The selection of apt words, short and to the point, projects the author's meaning best. How to select these words without making his style "choppy" is hard for the resident, as it is for almost anyone else.

When the galley proofs are received from the journal to which the resident has submitted his paper, the librarian can render a concrete service by reading them. It is mandatory that one person, other than the author, read the proofs for errors. The author is so familiar with his subject material that he reads it "correct" even though it may contain typographical errors.

May we make a plea here for absolute correctness in the References to all papers of residents, interns and physicians in general? The librarian is most likely to note these errors because of her experience with bibliographies where incorrect volume numbers are assigned to journal titles, incorrect paging and incorrect years. If these are all wrong, she must start from the beginning and use the standard indices; but when one or two items are wrong, the confusion is greater. These inaccuracies are not confined exclusively to small publications but occur in aggravating numbers in national periodicals.

Not only is the hospital librarian interested in the residents' publishing good papers, but she realizes that the hospital is represented in medical literature, by the published works of its residents and staff. She would like to have it said, "That must be a well-written paper because it comes from such-and-such a hospital." She, of course, is no judge of the medical and surgical standards of the hospital's work, but its style of being reported can be improved by her constructive criticism.

The current opinion is that too many papers are being published. There is always a place for a really good paper, and the hospital librarian has a small part in assisting in the production of such work.

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(List of references for this paper will be found in the amalgamated list of references on medical writing for all papers in this special issue of THE JOURNAL *on page 234.)*

The Medical Library and Medical Writing

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WHEN a physician-author looks around a well-stocked medical library he may be impelled to ask himself, "Is my article really necessary?" From the thousands of medical journals that pour into libraries every month, he might assume that writers have already said everything worth saying—and a lot that is not. But if he still feels that he has some new evidence, or a new view of established evidence, chances are that in all those publications he would find no piece exactly matching the one he plans to write. Medicine itself is so complex and dynamic that its literature can only grow and ramify, and any valid contribution helps strengthen the branches.

The medical library is the doctor's chief ally in his effort to produce a good sound piece of writing. The help the library offers is twofold: In the first place, it supplies rich sources of reference materials, as well as personnel to guide the doctor in his search. In the second place, it indirectly offers valuable instruction in the techniques of medical writing. The first function is recognized to some degree by all medical school graduates and undergraduates, but the second is apparently not so generally appreciated. It is conceivable that if all medical students were trained to use the library's resources fully and competently, medical literature might be considerably reduced in quantity and improved in quality.

Luckily for the physician-writer, the intricate science of medicine has been well documented for at least several hundred years—the first printed medical bibliography was published in France in 1506. Medical bibliography became established as an important branch of medical science with the definitive work of German scholars in the latter half of the eighteenth century. In the United States, achievements in this field have stemmed mostly from the work of John Shaw Billings, who built up and catalogued the Library of the Surgeon General's Office after the close of the Civil War, and established the *Index Medicus* in 1879. This index was the standard reference work until 1916, when the American Medical Association started the *Quarterly Cumulative Index*. The inevitable duplication between the two indexes led to their amalgamation in 1927, the result being the *Quarterly Cumulative Index Medicus*. Then came the *Current List of Medical Literature*, which was issued at first as merely an interim guide, and was sponsored by a group of scientists known as the Friends of the Army Medical Library. Later, under the auspices of the Armed Forces Medical Library, this index came into wide use as a permanent record and the only one that was really current. In 1956, the Armed Forces Medical Library became the National Library of Medicine, continuing to publish and improve the *Current List*. The summer of 1959 marked the end of an era, when the *Quarterly Cumulative Index Medicus* ceased publication; the final volume in the series is the one covering the latter half of 1956. The *Current List* then changed its name to *Index Medicus*, appropriately harking back to the momentous labors of Billings and others in mapping the field of medical literature. The monthly series of the *Index* is published by the National Library, and the yearly cumulative index is a joint project of the Library and the American Medical Association.

For the medical writer, the significance of this background lies in a point that is perhaps taken too much for granted: The establishment of the bibliographic approach to medical literature has made it possible for the doctor to survey prodigious quantities of material in a relatively short time and in a relatively small library. It has also meant that medical libraries have become teaching and service institutions rather than mere repositories, a principle that holds whether there is only one librarian to fill all roles or whether there is a large staff of librarian-specialists. And, incidentally, developments in the handling of medical literature have brought to medical schools the need for changed concepts; the schools are beginning to incorporate classes in medical bibliography as a separate discipline taught by qualified medical librarians. In time, such courses may replace the Journal Clubs that now serve to acquaint medical students with periodical literature in their field.

Essential to good medical writing is a solid acquaintance with the work that has preceded the author's in his special field, and so the writing can be considered to begin with a thorough search of the literature, both current and historical. The aver-

age doctor is familiar with general reference works such as the major medical indexes, encyclopedias, and dictionaries. He is aware also that the librarian will go to any lengths to obtain the material he needs. If he is writing an article that requires the citation of basic sources, he can often expedite matters by first combing his favorite texts, as well as by reviewing articles and monographs in his specialty. He should of course take complete notes on references he finds in such sources so that either he or the librarian can locate the original material promptly. He will find abstract journals, such as *Excerpta Medica, Chemical Abstracts,* and *Biological Abstracts,* useful for surveying recent developments in a field. Government documents, unpublished dissertations, special monographs, and rare books and periodicals usually lie in the province of the medical librarian and the inter-library loan service. Librarians can produce miracles for an author if only he provides enough key information about his needs.

When he arranges his material, the author will find that his working bibliography contains several times as many references as he needs for publication, and as his article takes shape he must boil them down to a requisite few. Here let him take heed of an immutable principle: Any source he refers to must have been read by him. If his information comes from an abstract or a digest, let it be so noted. If he quotes an ancient scholar from a modern history, let this source be fully credited. Above all, let him shun the practice (which no librarian would ever be a party to!) of lifting references en bloc from another author, saving labor but perpetuating error and inanity.

The actual writing begins in the library with the first notes the author puts on cards. He probably has worked out his own system for recording and abstracting his reference material; if not, or if he is seeking more effective ways to do it, he can find excellent suggestions in print. But whatever system he uses, the paramount requirement is absolute accuracy. Then there will be no need for him to puzzle his brain over inconsistent or impossible data, at midnight in his favorite hideaway two hundred miles from the library—or for some copy-editor later to waste his spirit in the search for nonexistent authors or articles among the references. There in the library, at the beginning of his work, the author can establish once and for all the correctness of every letter and numeral in each reference. He should retain in his notes and incorporate in the finished manuscript all pertinent bibliographic information: for journal articles, the full authorship, whole title, complete pagination, and the volume, month, and year; in addition, for books, the correctly spelled names of editors, publishers, and places of publication. It is better to include too many rather than too few details in a reference list sent to the editor of a journal.

On the basis of its general purpose and content, the article will fall into one of about six major categories of medical writing. The author would do well to spend part of his time in the library scanning similar types of articles strictly from the standpoint of writing techniques rather than content. Is the material clearly and logically organized? Does the language seem graceful, and, if so, how is this accomplished? Are the mechanics of grammar and punctuation handled competently? He will find article titles ranging from a cryptic word to a full-blown, fatiguing summary, and should note that the best ones have not more than eight or ten carefully chosen key words. He should examine introductions: Do they acquaint him with the reason for the articles and make him interested in reading further? And summaries: Do they review the contents adequately, so that they could stand alone as abstracts? If an author finds himself actually unable to distinguish between good and bad medical writing, he should seek help, for the sake of his own writing. Through the medical indexes, he can find many articles and books dealing specifically with writing techniques; these are copiously illustrated with samples of good and bad medical writing. He might take home with him some books by gifted authors (for example Osler or Zinsser) and read them slowly with his ear tuned to style rather than information. Simple practices like these can constitute a thorough course in medical writing.

When a doctor is toiling over an article, it may be hard for him to envision the finished product as an integral part of the tremendous literature that embodies all the creative ideas of medicine since the art of healing began. Yet there it will be, for better or for worse, his contribution to the process described by one sensitive librarian as "establishing our ties to the past and making our promises to the future." It is the responsibility of the medical library to maintain the vitality of this process, and the privilege of the medical writer to draw concepts from that source, distill them in a new form, and return the essence to be drawn upon in turn by others. Thus the medical library and medical writing form an inseparable symbiotic relationship.

(List of references for this paper will be found in the amalgamated list of references on medical writing for all papers in this special issue of The Journal *on page 234.)*

The Medical Abstract

Don Chalmers Lyons, D.D.S., Ph.D.
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WITHOUT the aid of available compilations of abstracts, medical authors and research workers today would find their task of investigation of comprehensive source material and precedents almost impossible because of the accumulation of hundreds of thousands of published articles. Search for previously published reports on a method, a technique, a discovery, or a precedent is extremely important if one would avoid the embarrassment that comes, too frequently, to investigators who publish without such careful background examinations. Such investigators have claimed new procedures, which to their later horror they have discovered were claimed and published many years before. This is especially true when earlier publication was in some other language.

Considerable confusion exists as to what is an abstract. Dictionaries of contemporary usage, in general, fail to define abstract in accordance with present use of the term. A difference should be noted between abstract and summary, conclusion, report, brief, and synopsis. Each of these forms has its own use, place, and characteristics. The one attribute they have in common is brevity. Directions issued by Biological Abstracts as instructions to their cooperating abstracters include a suitable definition: "An abstract should be a non-critical informative digest of significant content and conclusions of the paper, not a mere description. It should be intelligible in itself without reference to the original, but not intended as a substitute for it."*

The most important guide, then, calls for the abstracter to be non-critical and at the same time to tell a complete story. No matter how much he may disagree with the author's published conclusions, the abstracter's job is to make a truly "informative digest" that is intelligible. With the present flood of new drugs, new techniques, and new uses, it is often difficult to digest a poorly documented article. Authors frequently write without adequate documentation, thereby creating difficulties for abstracters who are expected to "digest significant content and conclusions."

*Biological Abstracts, 31(1):5-6, 1957.

Acceptable abstracts are written in established form. The abstract should begin with a statement of the complete title of the paper. If the paper appeared in a foreign language journal, the foreign language title should follow the English title. The second line should carry the author's name, his affiliation and his address, if these are distinctive; even though these often are omitted when printing space is limited. The original article usually carries the author's affiliation and address, or these are available from the editor or from directories to readers interested in communicating with the author. The third line carries the name of the journal and is followed by the issue number, first and last page numbers, a notation regarding illustrations, and the month and year of publication. This line is the most important part of the heading. It should be stated whether the journal is issued irregularly, quarterly, monthly, or weekly.

Some volumes are broken into sections or parts, and pagination may not be continuous, or it may be continuous through several issues or by annual volume. These facts should be carefully noted. It is extremely important that journal title abbreviations used be those generally accepted by *Quarterly Cumulative Index Medicus, Periodical Index,* or *Biological Abstracts.* JAMA usually refers to *The Journal of the American Medical Association;* but it could identify, to others, *Journal of the American Manufacturers Association,* of *American Metal Abrasives,* or of the *American Mortuary Association.* The following is an approved form actually published:

> An evaluation of the effect of cerebral palsy on dentofacial development, especially the occlusion of the teeth.
> Lyons, Don C.
> Jour. Pediat., 49(4):432-436, illus., 1956

The body of the abstract should state briefly, in complete sentences: the object of the paper and reported investigation; methods; apparatus; drugs used; and the author's (not the abstracter's) evaluation of new data, of theories, of techniques, and of results. No graphs, charts, tables, or illustrations should be included in the abstract. The abstracter may mention

that there are such in the article. Reference may be made also to the bibliography if this is extensive or noteworthy in any other way.

The abstracter should realize that the abstract is a tool used by many readers of varied interests who speak other languages; for this reason, as well as for avoidance of error, few abbreviations should be used.

Abbreviations should be limited to those of universal usage in all languages and accepted in scientific literature, including perhaps: pH; cc; ml.; C, or F, for temperature; %; BMR (for basal metabolic rate); ECG, EKG (for electrocardiogram); EEG (for electroencephalogram); oz.; RQ (for respiratory quotient); and others of this type. Grams and grains can be abbreviated, but too often g can refer to either, and gm. and gr. come out the same on the linotype machine. Species and genus names can be abbreviated; but S. might refer to Streptococcus, to Staphylococcus, to Spirilum, or to Spirochaeta. So, unless meaning is obvious, it probably is better that the abstracter not abbreviate and that he leave abbreviations to the editor.

The abstract should not contain detailed descriptions of new apparatus or of experiments. This should be left to the summary and to the review writer. New chemical formulas should be written out; but proprietary names of drugs and chemicals should be avoided. When absolutely necessary to use these, they should be identified with the proper symbol. Terms used to describe surgical operations should follow terminology acceptable to the American College of Surgeons.

Finally, the abstracter always should write with accuracy, brevity, and clarity, remembering that the more specific the words used, the more information they carry.

Drunk Drivers Often Alcoholic

In the current *Michigan State Bar Journal*, Melvin L. Selzer, M.D., instructor in psychiatry at the University of Michigan, says: "A few long overdue studies now appear to implicate the alcoholic rather than the casual drinker" as a highway hazard.

In 1948-49, he notes, nearly half those convicted of drunken driving in Sweden were alcoholics. A Canadian study indicated that a group of alcoholics accounted for two-and-a-half times as many accidents, nine times as many convictions for drunken and impaired driving, and six times as many license suspensions as would be expected in the general driving population.

Several independent studies of personality factors in alcoholics and accident-prone drivers suggest that "auto accidents and the alcoholic personality are often associated," says Dr. Selzer.

"It appears likely that a substantial percentage of motor vehicle accidents are caused by alcoholic persons. It is also possible that many persons arrested for driving while intoxicated are alcoholic.

"In view of their inability to stop drinking unaided, they represent a unique challenge in that they offer law enforcement agencies an unusual opportunity to prevent future accidents at the hands of the same potential offenders."

Three factors have resulted in failure to capitalize on this opportunity, Dr. Selzer adds:

1. *Public Hostility Toward Alcoholics:* In their handling of alcoholics, the courts and law enforcement agencies not infrequently permit themselves to be ruled by hostile and irrational considerations.

Remanding an alcoholic to jail, fining him, threatening him, or treating him with derision and contempt may satisfy legal and personal requirements, but actually represents a disservice to the alcoholic and above all to the community.

2. *Failure to Recognize Alcoholics:* This has been attributed to both the chronic inebriate's skill at disguising his drinking problem and the public misconception regarding typically alcoholic behavior. However, the alcoholic's intense unconscious denial of his alcoholism is an important factor.

3. *Lack of Adequate Treatment Facilities:* Many jurisdictions are forced to rely solely on jail sentences and ordering offenders to attend Alcoholics Anonymous meetings because little else is available.

"Although Alcoholics Anonymous has done a remarkable job with countless individuals, its appeal is limited to alcoholics who probably constitute a small minority of the alcoholic population," Dr. Selzer comments.

"Alcoholics Anonymous successes have deservedly received great publicity in a previously not very hopeful area of human misery. But this and the unavailability of other facilities have made too many professional persons regard AA as a panacea for alcoholics.

"Necessity is often the mother of conviction. AA has thus unwittingly become a bottleneck toward further progress in the treatment of alcoholism."

Where ordinary legal threats and punishment fail, coercion aimed at forcing the alcoholic to seek treatment will often succeed, Dr. Selzer says. "Indeed, compulsory means appear to be the only way to bring the majority of alcoholics into treatment."

The Medical Essay

Charles Sellers, M.D.
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FROM time immemorial, man has had a restless, inquiring mind and a wandering body. He has migrated to the most distant areas taking his knowledge and opinions with him. He also has an inclination to write about his inquiries, his wanderings and his observations. His writings take many forms including essays on various cultural factors which generally contribute to a better understanding of different people and to an eclectic selection of cultural values from many sources.

The medical essay is restricted in scope. Perhaps a definition would be an artful approach: this makes it possible to select the grounds for discussion, to claim a degree of specificity and to disclaim certain territory which may be untenable because of pitfalls.

The title, "The Medical Essay," is simple enough to be disarming and ambiguous enough to be disconcerting. It may mean different things to various persons. Perhaps the negative side can be stated more easily. For our purposes, the medical essay is not a history of medicine, a résumé of the literature and a report of a rare condition or circumstance, a description of an operative technique, a dissertation on a familiar disease, treatment, procedure or drug, or an analysis of 700 cases of a particular diagnosis on a hospital chart run through a computing machine. It is not a statistical report of the incidence of beri-beri in Buncombe County nor the number of web-toed Eskimos in the Mackenzie River Delta.

On the positive side, the medical essay involves a discussion in a field where there are elements of doubt and speculation. It may be an approach to the solution of some problem or a theory concerning the resolution of a previous uncertainty. Generally, it is a philosophical treatise on a controversial subject or one in which knowledge is incomplete and there is an opportunity for an attempt to marshall an array of evidence or argument for a particular viewpoint, or for all viewpoints. Perhaps we may say that a medical essay deals with or covers a wide concept in a narrow field.

An essay might be written about medical education, the carcinogenic factors in pulmonary malignancy or theories about the etiology of cancer in general. There would be an opportunity for stating personal experiences and opinions in each category. An essayist needs freedom to roam about in an unrestricted manner in a limited area, a playing field where he may volley ideas back and forth or take them from others and make efforts to reach successful goals.

On the other hand, a discussion on the familiar subjects of appendicitis, tonsillitis or Colles' fracture would not be suitable material on which to base a medical essay. There is no longer much mystery about these conditions. Their solution has been recent enough to be common knowledge and not remote enough to elicit romantic images.

Great events of the past in medicine make available to the medical essayist almost unlimited material for his consideration. Here are opportunities to revive little-known romances of medicine, splendid ideas and ideals, investigation of the unknown, research that proved to be fruitless and the brilliance of those that were triumphant. He can delineate a wide perspective and contribute to the general advancement of knowledge and culture by means of the written word in spite of the fact that some attrition takes place in competition for time and attention from potential readers.

The printed page is congealed thought transmittible as such to distant points and persons and reducible to its pristine state by readers. The medical essay should help the physician in his search for wisdom, which has been defined as a fleeting illusion, a universal perspective and an integration in time and space of those persons and events considered to be significant for all time. The essay aspires to be educational to the physician and of service to medicine. It may be used to stimulate a student to be a better physician by being a better man and to realize that he must be a good man before he can be a good physician.

Various kinds of essays have appeared in medical literature from early times wherever there was medical knowledge. In America, Oliver Wendell Holmes, of Harvard, became justly famous for his contributions to medical writing. His paper, "The Contagiousness of Puerperal Fever," which appeared in 1843 was almost simultaneous with a similar statement by Sem-

melweis but antedated Pasteur's demonstration of bacteria and knowledge of contamination by pathogenic organisms.

Another paper by Dr. Holmes, entitled "Borderlines of Knowledge in Some Provinces of Medical Science," was given as a lecture in 1861. It fulfills the description we have adduced for an essay as indicated by the title. A collection of the two mentioned and other essays appeared later under the general title of "Medical Essays, 1842-1882." These articles show familiarity with classical and medical literature and considerable experience in writing. They are descriptive and explanatory but perhaps a little verbose and contrived.

Sir William Osler frequently was asked to address various assemblies including the graduating classes of colleges in Canada, in the United States and in England. These usually took the form of essays on subjects tangent to medicine. Those published include "Acquanimitas," "The Leaven of Science," "Chauvinism in Medicine," "The Hospital as a College," "Man's Redemption of Man," "A Way of Life" and many others. Most of these essays were written before Dr. Osler left the United States for Oxford. Some of them dealt with current problems of that time but many are timeless and quite as cogent now as then.

The Journal of the American Medical Association has carried excellent medical essays at various times. We might suggest that *The Journal* devote itself more to articles of a general nature, those with broad viewpoints, presenting arguments or the philosophic approach to many-faceted problems. Technical and procedural papers then would gravitate to the specialties' journals.

William Dock, of Brooklyn, contributed a fine essay entitled "Curiosity, Culture and Curricula" to *The Journal* [JAMA 172:7 (Feb. 13) 1960]. He made a plea for the undergraduate medical student's study of the humanities and of social and of natural sciences during all the years he spends preparing to become a physician. He prefers the campus setting that is slightly removed from city distractions. Variety in medical education is more important than uniform "ideal" curricula and there should be better library facilities for individualized self-education.

William B. Bean, of Iowa City, wrote a splendid essay called "The Natural History of Error" published in the *AMA Archives of Internal Medicine* [105:2, (Feb.) 1960]. He says errors often are rampant and some wax and wane in a cyclic manner. In many instances, invalid opinions have prevailed long after contrary evidence became available. Consider: acidosis, autointoxication, viceroptosis, focal infection, tonsil excisions, thymus gland anomalies, "vitamania," and too implicit belief in the printed word and in intentional hoaxes.

A good medical essay should transport the reading physician on a journey across time and space amid ideas and images couched in lilting language for his cultural enrichment and for his scientific enlightenment.

The essential thing is not to have arrived but to have travelled.

Heart Research in Detroit

A study in Detroit of three great riddles of heart disease—including the basic problem of how to make a heart transplant "take"—will be financed by a grant of $226,941 from The John A. Hartford Foundation, Inc., of New York to Harper Hospital.

The grant will support three years of research at Harper and Wayne State University College of Medicine, with which Harper is affiliated.

Richard J. Bing, M.D., Detroit, will direct the project.

The specific goals are:

1. To study the physiological reasons why a transplanted heart (or other organ) is usually rejected by the body within a short time after transplanting;
2. To develop a reliable and fast method of measuring blood flow through the coronary arteries; (this is badly needed for diagnosis and care of patients with atherosclerosis, and particularly for patients who have suffered heart attacks) and
3. To study the metabolism of the heart and other factors involved in angina pectoris.

Medical Writing for the Hospital Bulletin

W. S. Reveno, M.D.
Detroit, Michigan

ALTHOUGH the Hospital Bulletin is essentially a house organ and its circle of readers is ordinarily small, it can serve the hospital staff as a medium for the exchange of experiences and the junior staff as a training ground for medical writing. Its contents need not differ greatly from those of the average medical journal. The costs of publication, however, place a limitation on size, number of illustrations and the use of professional help in the preparation and editing of manuscripts.

In the main, a Hospital Bulletin should be made up of short papers dealing with the following subjects: (1) case reports, including limited citations from the literature and a brief pertinent reference list; (2) reviews of certain types of cases prepared annually by the senior resident of each major department under the guidance of his chief; (3) preliminary, interim and final reports of clinical as well as laboratory investigations; (4) papers presented by visiting clinicians and by participants in staff-sponsored symposia on live medical subjects; (5) abstracts prepared by staff members of papers they have submitted elsewhere for publication; (6) brief reports on papers heard at national or regional meetings that would not appear in print for several months; and (7) a *Festschrift* or memorial number when the occasion arises.



The Author
W. S. REVENO
M.D.

All of these fit into the Bulletin format readily, but editorializing has little place in such a publication, and personal items detract where the subscription list extends beyond the immediate area of the hospital.

To be acceptable for publication, a manuscript should deal with a selected or assigned subject in approximately 2500 words. It should include a minimal review of the pertinent literature with a brief reference list, and conform to the generally accepted rules governing the physical characteristics of manuscripts.

A middle road between undue verbosity that overwhelms the reader and telegraphic reporting that leaves him breathless should be followed. Concentration on clarity, not cuteness, and a bending and blending of words and phrases to achieve that end will always be rewarded by heightened reader interest.

Since the manuscript is going to be short, the opening sentences might well give the reason for the report and enumerate the significant similar experiences of others. A description of the case or cases is then followed by a discussion of the salient points, and the entire presentation is then wrapped up with a neat summary or conclusion. The first or second draft of this manuscript should be reread after a few days so that the material may be rearranged if necessary, sentences rephrased, extraneous items deleted, omissions restored and spelling and punctuation corrected.

A Hospital Bulletin made up along the lines suggested and published at regular intervals, either in printed and bound form or as a few mimeographed sheets stapled together, can serve as an effective means of communication for the medical staff and as a training medium in medical writing for junior members. It is a worthwhile project for any sizable hospital staff.

The County Bulletin in Health And in Disease

A Brief Treatise Upon the Diseases Which Afflict or Threaten One of the Functions Which Make for a Coherent Profession

Hazen L. Miller, M.D.
Royal Oak, Michigan

WHEN a county medical society has outgrown its mimeographed news letter, it needs a Bulletin. This need will develop when the society approaches one hundred members. Communications then pose a problem which cannot be solved by meetings and by letters alone. Call it what you like (but be kind to it); a publication should come into being. It will soon prove its reason for being by providing contacts between members and by disseminating their thought. Announcements, the president's policies, committee reports of general interest, communications, minutes of meetings—all should be aired.

But most important is the editorial: the conscience of the Bulletin. If you ask anyone for an exact definition of an editorial, the chances are he will be hard put to furnish it. Webster's New Collegiate Dictionary defines it as "an article . . . giving the editor's views." So the editor and his men should have a store of views or ideas, preferably not entirely contradictory to each other. Without editorials, a Bulletin lacks identity, individuality and integrity; with them, it seems to live and to think and not merely to report. This should make it worth the editor's while to think ahead and to lay up a store of cogent thoughts to draw upon, or, better still, to extract them from his associates. Stated briefly on a well-spaced page or less, and given a compelling title and a by-line, editorials distinguish the Bulletin as a conscious, thinking entity in contrast to the vegetative publication with neither invention nor originality.

Editorials, of course, imply an editor. Indeed, the Bulletin would be an anencephalic monster without one. But when the qualifications of a good editor are considered, the smaller society newly planning a Bulletin may have qualms. For instance, any editor worth his salt (which in this case is the satisfaction of a good job well done) should have sound and tested principles. Unless he is prepared to recognize an issue when he sees one and to take a stand upon the principles involved, the publication becomes wishy-washy and meaningless. It would also help if the editor has a talent for being always right in his judgments. But this is not essential if he is fair and gives prominence to those letters setting forth opposing views, letters which he hopes for but which usually never get beyond the corridor cramp at the hospital. Intestinal obstruction stops them.

Besides an up-to-date acquaintanceship with all current medical problems, another desirable attribute for this ideal editor is a thorough knowledge of the classics, so that he may confound his critics by citing "wise saws and ancient instances." And last, most important of all, he should be willing and able to write.

Improbable as it may seem, the chances are that there are at least two or three men answering this description in any medical society numbering one hundred or more. Your man may not be writing medical papers for the journals. He may not be much of an orator; in fact, he may abhor the effort of elocution. He may have taken little part in society affairs because he is probably introspective and prefers thought to talk. But he is around somewhere if you look for him. The laws of chance predict his presence. When you consider the extent of literary education to which a pre-medical student is exposed, you must concede that someone somewhere in any given fifty or one hundred doctors got the general idea of communicating with his fellow man through the medium of words.

This man, this editor, with, let us concede, a few faults, having now been discovered, should be given a free hand. He will find his kind. Homogeneity is essential in an editorial board. He and his staff will find recruits and eventually from them will come the man who makes the editor a real success; namely, the editor's successor.

All the work need not be done by the editor and his assistants. Members can be found to contribute articles of more than editorial length and to present collected facts as well as personal opinions. These may be members of state society committees, chair-

men of county committees or anyone whose experience and wide reading has made him an authority of a sort. Such special articles may be on professional courtesy and ethics, on third-party medicine, on relations with public health and social welfare agencies, on the many facets of doctor-hospital relationships—there is no end to the possibilities.

The most factual offerings which the Bulletin can present are abstracts of meetings, both those of the Board of Directors and those of the society as a whole. These should not be elaborate, but clear. They should give the reader opportunity to know what is going on except for actions stricken from the record and actions taken in closed meetings.

The one most effective way of catching and holding readers is the establishment of regular departments. Thus, one such column may be a continuing analysis of current medical news, or sidelights on community affairs, particularly as they relate to medicine. Reviews of literature of all kinds interesting to the doctor could make another monthly column.

Excluding sex and other tales of violence, humor probably has the greatest appeal to readers. Too many professional and technical journals suffer from ingrown gravity. But where can you find humor? Genuine humorous writing is rare; it takes a remarkably inventive and imaginative mind without the strait jacket of conformity or the inhibitions of disciplined respect for revered institutions; but it probably has done more than any other type of writing to open paths for free and original thought. Examples are found in Rabelais and Molière, Sterne and Cervantes. Says Leo Rosten in his foreword to the *Return of Hyman Kaplan*:

> Humor is the affectionate communication of insight. (Satire is focused bitterness, and burlesque the skewing of proportions.)
>
> Humor is, I think, the subtlest and chanciest of literary forms. It is surely not accidental that there are a thousand novelists, essayists, poets, journalists for each humorist. It is a long, long time between James Thurbers.

News releases, like most things which come easily and in profusion, are not worth much. The best of them come from medical organizations; but even these have a high Fog Index, are too verbose and often arrive just after the deadline. By the next month, they are like ancient history (except for being well-known). No matter how scarce original material may be, the editor should not let the Bulletin be a victim of that insidious disease, propaganda. He will get it from advertisers plugging for a great new pharmaceutical discovery and presenting their pitch in the form of pseudoscientific reports. He will get it from press agents for some industrial institute trying to offset adverse publicity with respect to the effects of their product on the public health. Even politicians try to horn in; as will almost anyone with a special axe to grind. This easy source of copy, which makes of the Bulletin a tool, should be shunned.

Another debilitating disease of the Bulletin is triviality. It creeps in on personal items. Some one broke 80 for the first time at golf, or went to Chicago, or bought a new car, or caught a mess of blue gills. These are matters of little or no importance and require no thought. The reader's reaction is usually, "So, what?!"

The Bulletin should feature a President's Page as often as one is obtainable. Opinions expressed therein are those of the man who has been elected to lead the society. Consequently, they are endowed with prestige and respect. Fortunate, indeed, is the editor who has a president with opinions to offer and policies to present. These are the hormones which give his publication strength and virility.

Limited space does not permit a complete discussion of over-indulgence in advertising. This results in "adverdupois," a form of obesity in magazines which causes sluggishness and loss of interest. In order to preserve readability and a literary appearance, advertising should not exceed about 50 per cent of the space of the Bulletin. When genuine reading matter is staggered through a maze of advertisements, some simulating it and others on rigid cards or folding sheets, like maps or time tables, then that publication is on the downgrade. It has become little more than a catalogue which may while away the reader's time when he is otherwise unoccupied.

The county society should see to it that its Bulletin qualifies under postal regulations for second-class mailing privileges. These requirements are easily met.

Conclusion and Summary

The county medical society Bulletin should have specific objectives if it is to justify its existence and if it is to lead a worthy, well-rounded, healthy and useful life:

1. It should keep the membership informed and be both timely and accurate.
2. It should stimulate interest in major medical issues of the day.
3. It should bind members of the county medical society more firmly together.
4. It should amuse as well as instruct its readers.
5. It should encourage better writing.

Statistics and Medical Writing

G. Stanley Woodson
Vergil N. Slee, M.D.
Ann Arbor, Michigan

VIRTUALLY every article appearing in a medical journal today is a statistical paper. We are given reports of changing patterns of disease, of series of cases comparing methods of therapy, and of single cases which are of peculiar interest because of their nonconformity with the expected. The physician is faced with the problem of using, presenting and interpreting quantitative data.

This is not surprising, since we live in a world of numerical descriptions. Our communities are described in thousands of people. Of these, certain numbers or proportions are males and females, so many are young and so many are old. Ball players are given batting averages. Automobiles are rated in miles per gallon. The cost of living is given in comparison with past figures in order to show the trends of our economy. These are statistics used as pictures, compressing information into manageable size.

The future is unknown to us. Yet every day we are forced to make decisions involving future probable events. The decision as to the time to leave the house for the office is based on a statistical process. Starting with the desired time of arrival one makes quantitative allowances for the mode of transportation, the expected traffic, the problem of parking, the weather and other factors, finally selecting the departure time which will most probably meet the arrival schedule. This second aspect of statistics pervades our lives: statistics as a method for choosing between courses of action—making decisions in the face of limited information.

Since these two statistical processes, description and prediction, are integral parts of all our existence, it would be impossible for the medical writer to avoid them even if he should wish to give in to the average physician's professed aversion to statistics and suspicion of anything statistical. These attitudes are, of course, based both on lack of understanding and on experiences with bad statistics.

In a great deal of medical writing, the statistics really are of the descriptive variety. Vital statistics, data on morbidity and mortality, and series of cases illustrating new disease entities fall into this classification. From these descriptive statistics, concepts of probability and prediction, which belong to a more sophisticated area of statistics, are inferred. This is often done improperly. Large series of cases and the events occurring in these series are read with the attitude, based on intuition plus a smattering of statistics, that "the bigger the series, the more believable are the data." And the corollary is reflected in the derisive attitude toward the "series of one case." But, paradoxically, we profess to be skeptical of "statistics" and we welcome the publication of reports of one or two cases.

Elementary statistical methods used in description are relatively straightforward, understandable, and easy to master. These methods include the proper formation of tables and graphs, the proper use of rates to make comparisons, and the application of simple rules such as "you can't average averages" (unless you properly weight each average). These statistics give little trouble.

The problem arises when one wants to use past experience to govern future action, to predict, to generalize. The appearance of formalized statistical methods for these applications, with the introduction of terms such as "probability," "standard error," "t-test," "chi-square," and the like, often produces the usual reaction to anything poorly understood—a reaction of suspicion and fear. This situation is relieved tremendously when one realizes the actual identity of the process involved in deciding what time to start for the office, how to decide what is wrong with the patient (the most probable diagnosis) and the best treatment (that with the best possible combination of "pros" and "cons" under the circumstances).

In establishing a diagnosis, the physician combines elements of medical history, physical examination, laboratory and x-ray findings, giving each a value based on research and on experience. The weighted combination of these findings (some positive and some negative) leads to the (probable) diagnosis. In in-

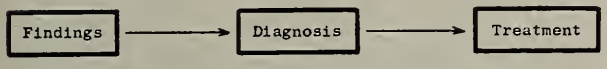
Mr. Woodson is the Biostatistician for the Commission on Professional and Hospital Activities, Ann Arbor, Michigan. Dr. Slee is Director of the Commission.

itiating treatment, the probable diagnosis, age, sex, complicating diagnoses, and other factors are considered along with the known properties of the possible therapeutic methods. There follows the selection of initial therapy based on the highest probability of success in curing the patient while doing him the least harm.

Statistical methods make systematic, orderly and quantitative these descriptive, estimating, predicting and generalizing processes. In medicine we make many such applications of statistics. For example, we determine five-year and ten-year survivals in cancer, we assay toxicity of drugs, and we evaluate their effectiveness. In the latter instance, medicine can justly be proud of its leadership in statistical methodology. The evaluation of streptomycin in treatment for tuberculosis is a statistical classic.

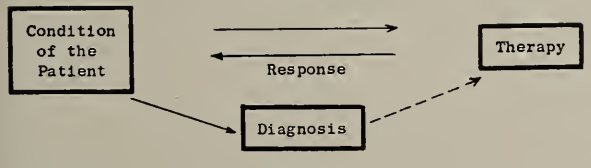
Another aspect of medicine is being considered through the statistician's eyes: medical diagnosis. Lusted and Ledley have offered a mathematical description of the diagnostic process. Their focus on this step in medicine appears to be a reflection of the traditional concept. (Diagram 1).

DIAGRAM 1



The more realistic diagram we propose (Diagram 2) indicates that labeling of the condition with a diagnosis is somewhat incidental to or at least parallel with decision as to management of the case, and that diagnosis and eventual therapy often depend on the effect of therapy.

DIAGRAM 2



On this basis, mathematical or symbolic representation of the care of the patient should be enlarged to describe actual processes employed by the physician.

With refinement and understanding of statistical methodology, there is a noticeable movement toward supplementing or replacing purely descriptive statistics with more refined and useful information. Most of the refinements are basically efforts to tell the reader how far and under what circumstances one can generalize from data presented. It is unfortunate that statistical methods have not become as familiar to the medical reader as to the medical writer. The author is expected to write with simplicity, precision, and clarity. Statistical notation and presentation are often the best methods of meeting these requirements.

The conscientious physician-reader should realize that the trend toward using these remarkable statistical tools is only beginning and that it would be wise for him to invest his time and energy in learning something about statistical language, methodology and philosophy. To this end, a list of useful "do-it-yourself" references has been placed in the bibliography.

The questions of statistical content and quality of medical publications involve the editor as well as the author. Publication policies increasingly allow more freedom in the use of tabular, graphic, and symbolic modes of presentation recognizing that, while costly, they are essential. It is also becoming more common for medical journals to give papers submitted for publication to a statistical consultant or panel for approval in order to insure that the reader will not be misled by papers with bad statistics. This is indeed a favorable trend and should help to protect the medical reader from a great deal of worthless "information." Nevertheless, methods of review must protect both the writer and the reader against a statistician who, not quite understanding the situation, may turn down valuable contributions to the literature or approve, on a purely statistical basis, material which may be medically misleading.

Even more important than statistical review at the time a paper has been prepared for publication is the use of the statistician in design and conduct of research. His enlistment at this point is by far the best practice and it is increasingly being employed in clinical and laboratory research. This move early in the game provides assurance of mutual understanding between physician and statistician. A well-designed experiment will be far more economical, as well as more reliable, than one in which little or no attention has been given to statistical principles. The advice of Hewitt on this point is very sound:

> If you contemplate an investigation that presumably will be sufficiently extensive to result in a paper much more complicated than a report of the case, you would do well to consult a statistician before you make any observations, do any laboratory work or collect any data. . . . If you are not a competent statistician and omit consultation with one who is competent, you may find yourself in crippling difficulty.

(List of references for this paper will be found in the amalgamated list of references on medical writing for all papers in this special issue of The Journal *on page 234.)*

Illustrations and Graphic Methods

S. J. Houtz
Detroit, Michigan

ILLUSTRATIONS are an international means of communication. Well-prepared pictorial and graphic material accompanying an article in a foreign language gives the reader an idea of the content of the paper, even though he cannot read the characters of the written word. Photographs, line drawings, charts, original records and tables are introduced in scientific and clinical papers to give the reader a clearer concept of methods or relationships which he would otherwise have to obtain from long verbal explanations.

The majority of medical journals publish periodically a page of instructions for authors wishing to submit articles for publication. These instructions should be studied and adhered to rigorously. The purpose of this paper is to suggest ways and means of obtaining illustrative material and graphic methods which will be acceptable for publication.

Photographs and Line Drawings

Many physicians do not have available the services of a visual aids department, thus they take their own photographs. A little pre-planning will produce results which are usually worthy of publication. Three important points to consider prior to taking a photograph are background, subject, and method of procedure.

A cluttered or "busy" background detracts from the center of attention (Fig. 1). In general, a solid or blank background is desirable. To eliminate an undesirable background, the objectionable part of the photograph can be painted with Chinese white (the eraser for India ink), or a line drawing may be made by tracing the important features on thin paper. Painting on a glossy print is difficult unless the area is first rubbed lightly with a small amount of saliva. This is more successful than using tap water. In deleting background, be careful to leave a base of support for the subject, especially if this is the way it appears in natural surroundings. At times, it may be desirable to design the background to show a relation between the object of focus (Fig. 2). This is particularly useful when patients are photographed at intervals to show progress under treatment.



Fig. 1. This photograph was originally 5 x 7 inches. Cutting two inches from the length removed part of the undesirable background. A part of the remaining background has been painted out with Chinese white to demonstrate how a photograph can be improved. Because permission for use of the photograph was not obtained from the persons, the faces were also painted out.

In photographing a patient, special attention should be given to his attire. Pictures of patients in partial stages of undress are neither pleasing nor professional. If a part of the anatomy is to be the focal point, drape the patient with the same care as that done for an operation. If the patient's face is to show, he should sign a release which will permit the physician to use the illustration for medical education or for publication. If release is not obtained, the patient's face should be covered while the photograph is being taken or blanked out on the print by covering it with Chinese white paint or a small piece of paper.

Standardizing a photographic procedure is of paramount importance when the purpose is to compare different patients or their affections, or progress under

From the Detroit Ortheopaedic Clinic, Detroit.

treatment. Because considerable time may intervene between recording pictures, similar and dissimilar characteristics are readily observed if background, position of subject, focal point, lighting, and distance

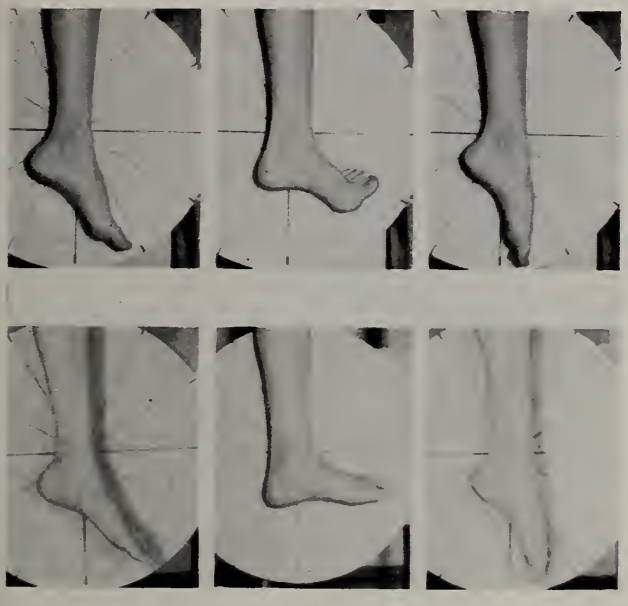


Fig. 2. The background was designed to emphasize the range of ankle motion before (above) and after (below) surgical intervention. *(Journal of Bone and Joint Surgery* 42-A:59-76, January, 1960)

from camera to patient are kept constant. Decide, before the first photograph is made: whether the patient should be standing, seated, or reclining; whether the camera should be on the same level, above, or below the central point; which type of illumination will emphasize the part or lesion illustrated; and whether the focal distance should be four or eight feet. Thereafter, use the same procedure for all subsequent photographs.

Depending on the subject to be illustrated, line drawings may be clearer and more descriptive than photographs (Fig. 3). Essential features of a photograph can be traced onto thin paper through use of an x-ray view box or similar transilluminating device. The tracing can then be transferred to heavy smooth pure white or blue-white Bristol board by blacking the back of the illustration with a soft pencil, placing it on the final paper, and going over the line drawing with a hard pencil. Another method of obtaining a line drawing is through use of an enlarger or a microfilm reader. The latter is found in many libraries. The enlarged picture may be projected directly onto Bristol board and the essential features outlined. This method eliminates transferring the drawing from thin to heavy paper. The drawing should be finished with India ink and the paper cleaned with art gum eraser. Line drawings should be from two to four times larger than expected when published because minor irregularities become invisible during photographic reduction. The stippled effect of the Ben Day process may be produced by use of Zip-a-Tone which is available in a large number of patterns at most art supply stores. It can be used effectively and is easy to apply.

If services of a visual aids department are available, the physician should be certain that the photographer or the artist understands in detail exactly what the picture is to illustrate. Consultation with the photographer prior to his taking a series of pictures will insure the desired results.

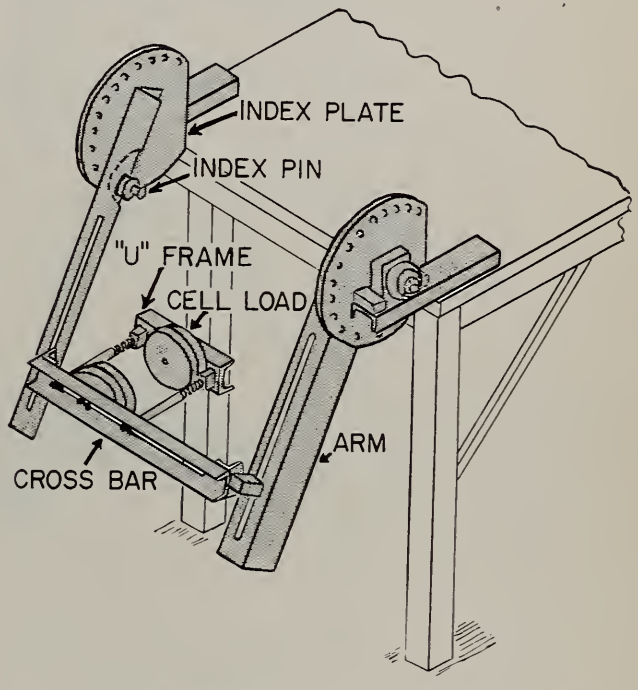


Fig. 3. This line drawing has been reduced from a 5½ x 6 inch illustration. The lettering is incorporated into the confines of the outline. Zip-a-tone was used to emphasize the important feature in the drawing. Lines under the table legs give the impression that the table is set on the floor and is not suspended in mid-air. *(Journal Applied Physiology* 11:475-480, November, 1957)

Graphs and Original Records

A graph or a chart presents pictorially columns of figures, masses of data, or relationships which the reader can grasp quickly. Statistical material, in general, can be classified with reference to comparisons of size, to dates or time, to frequency or age distribution, to correlation between other factors, or to geographic distribution. Graphic presentation may be in the form of a bar, a pie, a curve, a scatter dia-

gram, a map, or a flow chart. In graphs having co-ordinates, the usual practice is to plot the independent variable on the horizontal axis and the dependent variable on the ordinate (Fig. 4). Dates or intervals of time, in general, are plotted abscissa. The most important criteria for deciding method of presentation of data is that which best illustrates the picture clearly and simply.

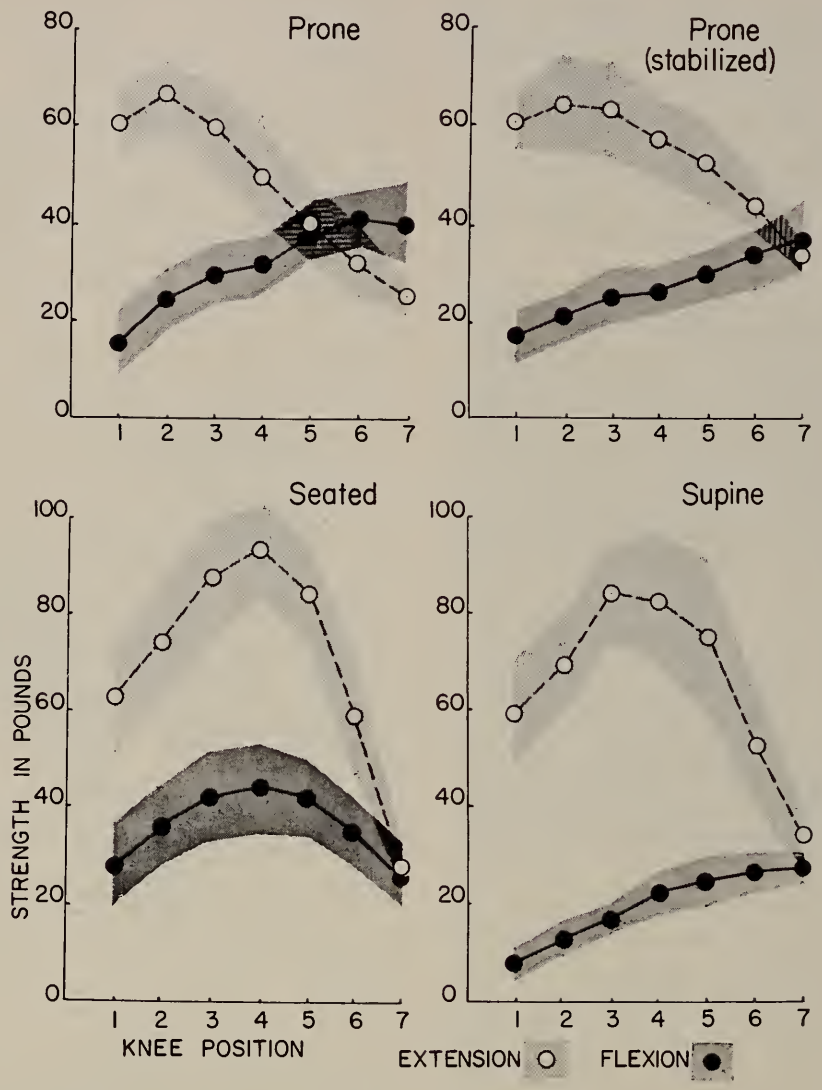


Fig. 4. Curve graphs which show one method of illustrating mean and standard deviation of the mean by use of Zip-a-tone. Because the co-ordinates are the same on all graphs, only one is labeled. The labeling was done with a LeRoy Lettering Set. (From same article as Figure 3.)

After trying several methods for illustrating data, the clearest graph can be transferred from the work sheet on to Bristol Board in the following way. Place the graph over heavy white paper and with a pin prick holes in the points of the graph, the beginning and end of coordinates, and the scale on each axis. Remove the graph and connect related points on the chart. Then finish it in India ink and label. A drop bow pen is recommended for making circles; a ruling pen for straight lines. Placing a strip of adhesive tape on the underside of the ruler prevents ink from running under it. Ben Day process may be used to emphasize points as desired.

Pale background lines of all colors except red and black can be burned out by using contrast processed film during photographic reduction (Fig. 5). This special technique for removing background lines from original records and from graphs usually is not done by the printers publishing professional journals. If lines are to be deleted, the author or his institution

usually must bear the cost of reproducing a 5 x 7 glossy print. This then accompanies the paper for publication.

throughout the word. To avoid overcrowding the illustration with unnecessary labels, explanations should be put in the legend.

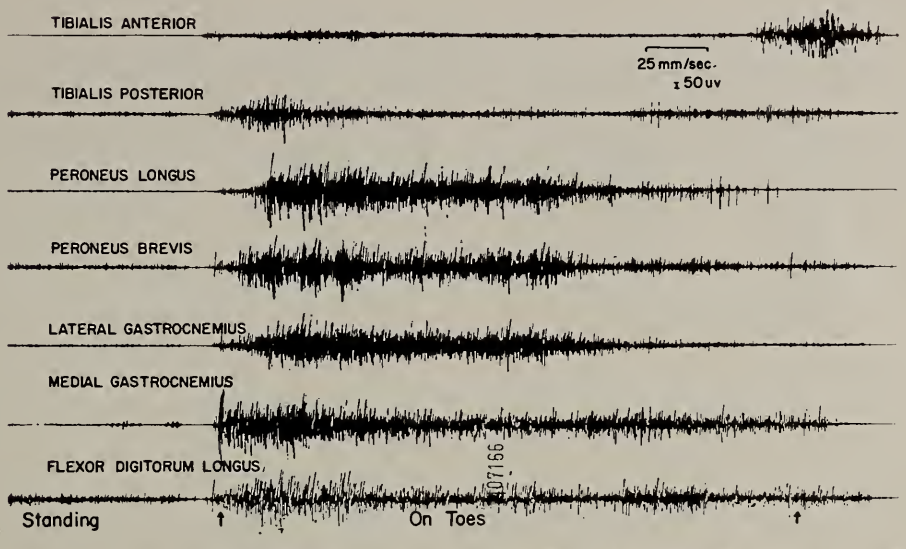


Fig. 5. Electromyogram reduced from original recording 9 x 14½ inches. The green background lines were burned out (notice chart number remains) by using contrast processed film when photographing the original record. This was done by a commercial photographer and the reduced 5 x 7 inch glossy print submitted for publication. Special processing usually is not done by the printers publishing the journal. (*Journal of Bone and Joint Surgery* 41-A:1469-1481, December, 1959)

Lettering

Labeling for illustrations can be done either free hand or with a lettering device. The novice with a little practice will produce professional like letters by using either a LeRoy Lettering Set or the Wrico lettering guide. Use of a lettering device insures constancy both of size and of type of letters. Commercial Gothic or Modern Roman alphabets are the letters most commonly used for medical illustrations. In some instances, it may be possible to purchase from an art supply store printed letters, numbers, symbols, et cetera, which can be pasted onto the illustration.

Letters, when reduced for publication, should be easily read. Legibility depends on the size of letter, spacing, and distribution of ink throughout a word. Usually narrower letters are more difficult to read. The same is true of those which have greater width than height. Too little or too much space between letters reduces ease of reading. Because of optical illusions, round letters (O,G,) should be closer to each other or to a straight letter (I,N,) than when straight letters are placed next to each other. Slanted letters (V,A,) occurring next to each other should be placed very close together. Lines of letters should be of the same thickness and of uniform degree of blackness

Tables

A table is a short-cut means of presenting numerical data. It should be arranged to emphasize primarily one point or a single relationship. Generally tables present either original data which characterize patients or classify materials, or derived data which summarize or point out results (Fig. 6). For each type of data, there is usually one form of table which presents important points more clearly than any other arrangement. After condensing and tabulating statistical material to obtain clarity, every item should be checked and rechecked for accuracy.

Each table should be typed, double space, on a separate page. Three cross rules should be included: one at the top; one below the box heads; and one at the bottom of the table. Footnotes should be placed below this bottom line. Standard abbreviations should be used for column headings and these should be consistent each time they occur in tables.

Summary

Suggestions herein presented are primarily to give the author a few "tricks of the trade." Additional information may be obtained in most books on medical writing listed in References which appear in this issue

of THE JOURNAL. It would be well to consult one of these as well as the list of suggestions supplied by the editor of the journal to which the paper is to be sent.

TABLE II

DATA ON PATIENTS WITH ANTERIOR TRANSPOSITION OF THE PERONEAL MUSCLE

Patient	Year and Month of Birth	Age* at Onset	Age* at Operation	Years between Onset and Operation
J.B.	June 1942	2	14	12
L.E.	June 1948	3	9	6
C.A.H.	April 1945	8	13	5
C.H.	January 1949	2	6	4
W.J.	June 1940	14	18	4
M.O'R.	September 1943	7	14	7
D.P.	May 1941	11	14	3
K.S.	December 1943	2	5	3
H.S.	October 1942	4	15	11

*Ages given in nearest years.

TABLE I. SIGNIFICANCE OF DIFFERENCE BETWEEN MEAN STRENGTH AT EACH ANGLE OF FLEXORS AND EXTENSORS OF THE KNEE IN DIFFERENT POSTURES

Position	Seated—Prone 31 tests*	Seated—Supine 28 tests†	Prone—Supine 29 tests†	Fixation—Free 29 tests†
		Extension		
1	0.44	0.68	0.41	0.22
2	2.01	1.19	0.78	0.30
3	6.66	0.68	6.35	1.01
4	11.69	2.23	6.88	2.24
5	12.54	2.70	14.24	3.92
6	6.83	1.28	5.11	4.71
7	0.71	1.70	4.39	5.92
		Flexion		
1	4.46	8.34	3.95	0.63
2	4.21	9.50	6.45	1.58
3	4.28	9.47	7.11	1.87
4	3.94	7.45	5.59	2.87
5	1.38	6.47	6.69	3.86
6	2.63	3.89	8.39	2.91
7	5.48	0.79	5.68	1.04

*t of 2.75 at 0.01 level.
†t of 2.76 at 0.01 level.

Fig. 6. Photographs of published tables set in type by printers of two journals. The "open" table is typical of those published in *Journal of Bone and Joint Surgery* (41-A:59-76, January, 1960). The "ruled" type is characteristic of *Journal of Applied Physiology* (11:475-480, November, 1957).

The following check list may help in preparation of illustrative and graphic material in connection with writing a paper for publication.

1. Do the illustrations and the graphically presented material contribute to clarity?

2. Do they present material effectively without written explanations?

3. Is each illustration with its accompanying legend, or graphic material with its heading, so clear it can stand alone as a complete entity without additional explanation in the text?

4. Is each table properly condensed to illustrate clearly one point or relationship?

5. Is the lettering in the illustrations readable when reduced?

6. Do the illustrations and the graphic materials substantiate the purpose of the study and concur with the results presented in the body of the paper and in the summary?

If the paper is well illustrated, the author can devote the greater part of the text to comparisons, to inferences, to interpretation of data, and to discussion of results.

Duties and Responsibilities of an Editor

Louis J. Bailey, M.D.
Southfield, Michigan

IN DESCRIBING editorial or "news" policy for the small magazine of the county medical society, it is well to distinguish immediately between the identity of the editor of such a magazine and the editor of the usual commercial or smaller house organ. The editor of whom we speak will be an amateur almost certainly; he will be of the grass roots, as a rule, and will have been chosen because of his devotion to the science of communication and his already demonstrated willingness to give of himself in medical society affairs.

Let us also recognize that the reader public of this magazine is guaranteed to the editor since the publication automatically is a membership privilege.

So, with an amateur editor and a guaranteed reader public, what constitutes good policy?

The editor *must be responsible to an officer or board within his society.* Since he is appointed, he will be responsible to the president; in a larger society, he will be responsible to the Council; but always, matters of policy, whether official actions of the society, or simple decisions affecting editorial policy, should be decided jointly by the editor and by the officer or body to which he is responsible.

Further, if the editor is responsible to official policy as determined by the executive officers of his society, he is also responsive to reader opinion. His editorial policies will stem from needs and opinions of his readers. His purposes are to inform them; to hear from them; to organize them in respect to local effort; to orient them as a local society to their part in a broader program; to bring unity through information and news.

The news policy of the magazine must be calculated to fit the organization into the larger plan of which the local society is a part.

Statewide movements, national programs, activities of lay organizations with medical purposes, all will require reporting, comment, and fitting into the local setting. Readers must be kept informed of these and, by editorial comments, of opinions and of policy within the society.

The editor needs a road map. How will the magazine be made up? What will be its content? Will it be uniform from issue to issue?

As you know, the *Detroit Medical News* frequently, though not always, has a lead article. There is an editorial, a listing of coming events, and special contributions, such as "By the Way" by Dr. Stapleton, and "Rant and Rave" by Dr. Lightbody. These have good reader interest.

Then, too, the official activities of the Council are reported at appropriate periods; some news events, capsule comments such as Dr. Reveno's "On the Run," book reviews, health department reports, and advertisements complete the book's content.

In earlier issues, *Detroit Medical News* had rather more reports on personal experiences, such as births, deaths, illness, and trips of doctors and their families, than we see today. It made for a folksier magazine of historical value. Such a magazine has little or no interest, however, for editors on exchange lists.

Reports of events and activities are of value. In former years, *Detroit Medical News* also received synopses of articles from the scientific literature—I believe from a clipping service. These made interesting and historically valuable reading.

Guest essays and editorials have their places. They provide reader interest and, at the same time, enlarge the number of your contributors. The guest editorial is a suitable substitute for thoughtful and thought-provoking readers' contributions in letters to the editor; and certainly, readers' contributions are to be courted. Readers feel that they are part owners and part managers of the publication. Readers' proprietary interest was mentioned earlier. Their views and comments should be integral parts of each issue.

The difficulty, of course, is to obtain carefully con-



The Author

LOUIS J. BAILEY
M.D.

Presented at the Second Editors Workshop for County Medical Society Bulletin Editors, January 30, 1960, in Detroit.

Dr. Bailey is Assistant Editor, THE JOURNAL of the Michigan State Medical Society.

sidered and well-written constructive comment on issues of the day. An instance comes to mind of a particular atrociously written letter—with respect both to construction and to spelling—which appeared in *Detroit Medical News* many years ago. It was printed as written, rather obviously that it might serve as its own rebuttal to the views expressed by the writer. But, as pointed out in the beginning, the editor is an amateur.

All letters, even those with the negative point of view must be answered; whether they are printed should be left to policy determined by the editor, executive officer or board, or editorial board if this exists.

But in this connection, the editor must not lose sight of his responsibility for all that appears in his publication. In his writing, he will need good diction and proper syntax; he will do well to develop a style (preferably fairly uniform, whether this be gaily informal and chatty, or reserved and formal); he will scrutinize and pass on the quality of that which he accepts from associate editors and from contributors. But always, in the last analysis, he is responsible for all that appears in his magazine. To this end, news policy will include acceptance for printing those reader comments which conform to principles of propriety which he applies to himself.

The editor should be objective. Since he is part of the organization he serves, he is likely to share opinions which may be held in controversies or proposals which may be under discussion.

He may be drawn into a running series of commentaries by means of correspondence; but it is not the best editorial policy to engage in or to permit the periodical to become an instrument for such debate.

The editor should attempt to organize, to unite, and to inform. His editorials should present points of view provoking thought; they should avoid exploiting the editor's pet aversions and predilections.

It is the duty of officers of the society to deal with controversial subjects. It is the editor's duty to report thereon: to explain how official attitudes have been adopted; to inform in a manner helpful to members of the society.

Undefensible statements should be avoided. Often, in reading a contribution, merely asking if this or that statement can be defended can help the editor decide on the appropriateness of the publication. As the person solely responsible for all that appears in the magazine the editor must be assured of defensibility before he can accept controversial material for publication.

This is not to say that in comment on official action, the editor is a pusillanimous nitwit. For example, a comment on action of the Judicial Council of the American Medical Association will suffice to illustrate the point: An editorial thereon drew a searching questioning commentary from a prominent and responsible physician. The editor stated what he considered the basis for his point of view and was able to show that his wording had not stated that the Judicial Council was wrong; he had stated that the effect of the Council's action was so and so. The reader was left to judge whether this effect was good or bad, right or wrong, acceptable or unacceptable.

Use of words is a fine art and, while shades of meaning are not to be carried to a legalistic absurdity, connotation of written words must be clearly defined and defensible.

Possibility of libel should be mentioned. Just as the concept of the corporate practice of medicine is so frequently misunderstood, this bête noire of the amateur editor, libel, is misunderstood; yet it is easily defined.

Libel is the printing of that which may damage the reputation or defame the character of a person. The law protects individuals from scurrilous writing, direct or indirect; it does not apply to that which is true and in the public domain.

Editorial policy permits criticism of ideas and of things, but under no circumstances should it permit criticism of persons. Print nothing which might be questionable on these grounds.

Summary

Editorial policy will include planning how the magazine is to be made up, what is to be included; reader representation and contribution will be sought; readers' comments, pro and con, will be thoughtfully and carefully answered, but the publication will not be used as an instrument of conflict which may disunite the society's members. The editor will keep currently informed, and advise his readers. Editorials will be written clearly and will avoid obscure or arch references to events or situations known only to the editor himself.

Editors might well look to the past of their periodicals: that which was good might profitably be reviewed and republished as of historic interest, forgotten but revived. Even the amateur editor will want to improve his publication, keeping it ever fresh, crisp, and new, but not entirely divorced from the past.

New Approach in Doctor-Patient Relationship In a Government Hospital For Long-Term Patients

V. K. Volk, M.D., Dr.P.H.
Saginaw, Michigan

THE IMPORTANCE of a close relationship between doctor and patient, based on free choice of physician, has been recognized for many years. In the past, these bonds were especially strong because the family physician supervised the health of the entire family and thus acquired knowledge and understanding of the needs and problems of each of its members. To these families, the doctor was more than physician; he was friend and advisor, even on problems which may not have had any direct bearing on health or sickness.

Although this type of patient-physician relationship is not as strong now as it was a generation ago, it still gives strength to our system of medical care. It has been weakened to some degree by extension of specialization. Contact with specialists is usually temporary and occurs only in special situations.

Currently, most patients with moderately severe or severe illness are hospitalized. Since many doctors are overworked, there is often lack of communication between doctor and patient with the result that many patients do not understand their own conditions. Certainly, this is a situation desired neither by patient nor physician; but often the patient accepts it uncomplainingly with confidence that the doctor will tell him of important things when necessary. Undoubtedly, the bridge of friendship between family doctor and patient helps to make up for any lack in communications.

A different situation exists, however, when the patient is admitted to a government hospital; no previous bond exists between the patient and a doctor he has not chosen. The hospital doctor, seeing the patient for the first time, tries to establish rapport. This imposes both burden and responsibility on the hospital physician. Usually, hospital staff doctors and hospital administration make a special effort to fill this gap.

This is not to suggest that care of patients in a government hospital, either by full-time or by part-time physicians, is less adequate and conscientious than similar care of patients in non-government hospitals. The physician in a government hospital simply has more difficulties to overcome because of lack of earlier relationships. This problem is especially acute in a hospital for patients needing long-term care.

On the basis of many years' experience as an administrator of a hospital for tuberculosis patients, I initiated, in 1953, a program for better communications between doctor and patient. This program has been acceptable to all concerned and contributed to better understanding between doctor and patient.

Hospital care for tuberculous patients often is difficult because confinement frequently is dictated not only by treatment but also by public health requirements. Clinicians primarily interested in tuberculosis know that many patients believe they are well enough to go home and insist that they no longer need to be hospitalized.

Many have strong feelings about what they believe unnecessary hospitalization. Such suspicion in itself creates difficulties both for doctors and for hospital administration.

For instance, some patients talk of differences of doctors' opinions even though differences in clinical assessment about needs and conditions of patients have not been stated. Such conclusions have been drawn by patients because different physicians have different ways of analyzing patients' problems and of expressing their ideas in their own words. Although findings may be similar, differences in expression may be misinterpreted and create unpleasant situations.

Week-ends, when the regular physician may not be on duty, seem to be "field days" for some patients, because the physician on call usually is not in possession of detailed clinical data pertaining to each patient. Some resultant problems are easily resolved; but often decisions made under these circumstances are difficult for the patient to accept. Obviously, such situations could be prevented if certain basic premises obtain:

Dr. Volk is Medical Superintendent of the Saginaw County Hospital.

1. Patients are entitled to detailed information about their illness and the hospital administration must provide relevant information.

2. Information given to the patient must be authentic and related to current status.

3. Resident physicians should be able to provide information at any time on the basis of collective judgment of the staff rather than upon the opinion of the individual staff physician.

4. Information must be available to the patients in writing because: (a) patients forget the spoken word, and (b) many interpret information through wishful thinking rather than by facing facts as actually given them by the doctor.

Others also need relevant information on problems presented by tuberculosis patients, public health aspects as well as medical: The health department needs to be kept informed on individual patients' progress; and family physicians, too, need to know about their patients' progress since during the period of hospitalization for tuberculosis they will have been out of touch with their patients.

Since 1953, to meet these needs and to establish continuous communications, letters have been written at regular intervals to each patient: (1) immediately after his case was considered by the staff, usually at the first staff meeting after his admission; and (2) every three months thereafter.

These letters are written by resident physicians and reviewed by the medical director of the Tuberculosis Division of Saginaw County Hospital. The original is sent to the patient; a copy is placed in the patient's record file where it is always available to all resident physicians; the second copy is retained by the resident physician dictating the letter; a third copy is sent to the local health officer; and the fourth to the family physician.

Letters to patients usually are concluded with this statement: "If you have any questions concerning this letter, or your case, please do not hesitate to contact me at any time." Many expressions of appreciation that come to us from family physicians indicate need for such information.

I believe much good has been accomplished by these letters. The patient recognizes the validity of the letter because he knows it is an official medical record; experience has convinced us that writing letters to patients every three months is good hospital practice, resulting in understanding and good will.

The plan in operation has resulted in some valuable by-products: when writing such letters resident physicians must be accurate; hence they must be thoroughly familiar with the patient's record and with his condition at the time of writing; an economy of time results because the letters eliminates the necessity of answering the patient's questions about his condition from day to day for the doctor needs only to refer the patient to his letter. Information provided in the letter also helps nurses, practical nurses, and student nurses to understand the patient's needs.

Frequently, the question arises, "How do you write to patients about unpleasant developments?"

Certainly, not all patients get well, and some fail to be cooperative. It is easy to write pleasant things to patients when they progress favorably. When it is obvious that they are not making good progress, we are as frank in writing to them.

A few examples of letters sent to patients may be of interest. Some of these relate to the patient's condition on admission; others, to the course of the disease; and others, to discharge. Our several years' experience has demonstrated to our satisfaction that the procedure is worthwhile, with benefit to patients, to family physician, to health officer, and to resident physicians.

I have no hesitancy in recommending that other hospitals try a similar plan, which might even be appropriate for application to patients and to resident physicians in general hospitals.

Conclusion

On the basis of our six years' experience, we find that letters written by resident physicians to patients have brought better understanding between doctors and patients; and that resident physicians, since they must be in possession of detailed information on the condition of each patient before writing these letters, are better informed about their patients.

Letter Sent to Patient Soon After Admission

Mr. H. L.
Saginaw County Hospital
Saginaw, Michigan
Dear Mr. L.:

In keeping with the policy of the Saginaw County Hospital, each patient is sent a letter of information following the presentation of his case in regular medical staff conference. In this manner, the patient is kept informed as to the progress made during his period of hospitalization. This is your first such letter.

Chest disease in your case was first suspected in 1953, and thorough study of your case led to surgical operation involving the left lung that same year. Our records are not as yet complete, but I can find no evidence of active pulmonary tuberculosis at that time.

During the past summer, however, your physical condition and your chest x-rays showed changes suggestive of active, pulmonary tuberculosis, and you were hospitalized at St. Mary's Hospital on August 1, 1956. Although all tests at that time failed to show active tuberculosis, your physi-

cians quite wisely persisted in repeated examinations, in order to determine the exact status of your chest. Further studies completed at St. Mary's Hospital following your readmission on September 27, 1956, resulted in a positive diagnosis of active, pulmonary tuberculosis, and you were admitted to the Saginaw County Hospital on September 29, 1956.

Our studies confirm this diagnosis, Mr. L. Your chest x-rays have been thoroughly studied, and we have been able to find the germs of tuberculosis in your sputum samples. Treatment has been started and includes isoniazid and para-amino salicylic acid (P.A.S.), two of our most potent anti-tuberculosis medications. In addition to the medicines, you are receiving, you have been placed in an activity classification designed to measure and limit the amount of activity you should undertake. You are in Class D. In addition to the items listed on your classification card the following is worthy of emphasis:

1. Rest in bed as much as possible.
2. Use a wheelchair for all transportation.
3. You have limited time (prescribed) for sitting indoors and occupational therapy.

Do not overlook that first item, Mr. L. Rest and regular rest periods are equally as important to you as the medicines you are taking. Without sufficient and adequate rest these medicines cannot do for you all that might otherwise be expected of them. It would be impossible for me to overemphasize this.

The medical staff is anxious that your period of hospitalization be a pleasant as well as a physically profitable one, Mr. L. If you have any questions concerning either this letter or your case, do not hesitate to bring them to me.

Sincerely yours,

_____, M.D.
Resident Physician
Saginaw County Hospital

Letter to the Patient in Need of Surgical Operation

Mr. W. O.
Saginaw County Hospital
Saginaw, Michigan

Dear Wilbur:

Your case was again presented at staff conference on December 3, 1956. It was the opinion of the doctors present that the chest x-ray of November 21, 1956, showed no definite change in the lesion in the right lung. The sputum examinations still continue positive for tubercle bacilli. Your general condition is quite satisfactory.

As we have previously told you, surgical operation is still the procedure of choice and you still have not consented to this. You will, therefore, still continue in Activity E, and also with routine sanatorium care.

When you have any problems relative to your case, please do not hesitate to discuss them with us. We extend to you best wishes for a Happy Holiday Season.

Respectively yours,

_____, M.D.
Resident Physician
Saginaw County Hospital

Letter to Patient Following Separation Conference and Discharge

Mr. N. S.
Saginaw County Hospital
Saginaw, Michigan

Dear Nelvern:

This letter is written to record for you and for us the conversations we had at the time of your discharge from Saginaw County Hospital on July 18, 1956. As you know, you have been hospitalized at Saginaw County Hospital since February 15, 1955. The x-rays showed widely distributed disease in both lungs which has the appearance of tuberculosis of a type which had developed gradually over a period of years.

Although the disease has not been very active it has produced extensive scarring in the lungs. Although we have not found the germs of tuberculosis in the sputum, the x-ray evidence suggests that there had been many germs in your system producing the disease. As tuberculosis is a disease that continues for a long time and sometime causes trouble even after apparently having become inactive, it is important that you be aware of the possibilities of a future unfavorable change. In order to avoid such a change, it is necessary that you continue living each day with adequate rest including at least 2 hours of bed rest after the noon day meal and sufficient nutritious food that your health will be at its best.

As there is some light outdoor work which you may be doing when weather is good, I am sure you will have no need to try to go back to your work at least for several months. If later, a very light job under favorable working conditions can be obtained, it might be all right to go back to employment there.

While you were at Saginaw County Hospital, you were getting streptomycin and para-amino salicyclic acid (P.A.S.). It will be somewhat difficult to take streptomycin which is given by needle after you are at home; consequently, we have discontinued this and you are to take isoniazid, which will be supplied to you in small white tablets, each tablet containing 100 milligrams. You are to take one each morning and one each evening. You will also continue taking P.A.S. to the extent of 20 tablets per day.

If at any time, you question whether everything is all right do not hesitate to come back to see us. If everything seems all right, I suggest that you come back on the 26th of October for re-check examination. With every good wish for continued good health, I am,

Sincerely yours,

_____, M.D.
Resident Physician
Saginaw County Hospital

Amalgamated List of References On Medical Writing

J. P. Gray, M.D.
Detroit, Michigan

The several authors of papers published in this special issue of THE JOURNAL MSMS, in keeping with good practice in writing, cited references on medical writing. As one might expect, several standard references on the subject were cited by most authors. Conversely, several other published works on technical writing, of possible interest because of proved value, were omitted. In an effort to provide a good working list of references on medical writing, the editorial committee of the Michigan Chapter of the American Medical Writers' Association decided that an amalgamation of the several authors' citations, with duplications deleted and with some additions, mainly of basic standard resources, would serve most readers of THE JOURNAL better than repetitive lists appended to each article in the usual manner. In some instances, references were cited by individual authors on related fields, but these have been deleted, except for those related to statistics, since it seemed desirable to limit references to those relevant to medical writing to statistics herein.

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Birth Defects—Cleft Palate

Nearly 100 per cent of the children born with cleft lip and palate can be helped by surgery, but it takes an entire team of health specialists to correct the physical and emotional effects of this birth defect.

James R. Hayward, D.D.S., oral surgeon at the University of Michigan Medical Center, says that cosmetic correction of cleft lip and palate is only part of the rehabilitation procedure. It is equally important to restore the child's ability to speak and eat, and to guide his mental adjustment to the defect.

For more than six years, the University of Michigan cleft palate team has combined its variety of specialized skills to restore children born with the disorder. The specialists represent pediatrics, oral surgery, otolaryngology, speech therapy, prosthetic, orthodontic and children's dentistry, and psychiatry.

The abnormaliity strikes one child in every 700, second only to clubbed feet in frequency. It occurs before the tenth week of pregnancy when the two halves of the upper jaw, which form the roof of the mouth and parts of the lip, do not fuse. The resulting gap widens as the embryo continues to develop.

Causes of the defect are unknown. Research, hindered by lack of funds, hints that one possible cause may be traced to heredity.

Within the first weeks after birth, surgeons restore the lip. They postpone the more extensive correction of jaw bone and soft palate until the child is about two years old. Dr. Hayward says too early surgery on the cleft palate may hinder further growth.

Cleft-palate team members keep a continuing check on the child's progress, often until adolescence: middle ear infections to which the victim is especially vulnerable require the attention of otolaryngologists; orthodontists straighten the jaw and teeth.

Normal speech is the ultimate goal in the cleft palate treatment, Dr. Hayward points out. Throughout the rehabilitation process, clinicians teach the child to develop speaking abilities. He says surgery alone can restore normal speech in only 10 per cent of the cases; most require extensive help in speech correction.

The New Look in Food Poisoning Control

W. L. Mallmann, Ph.D.
East Lansing, Michigan

As a BACTERIOLOGIST interested in environmental health and all ramifications of microbiology pertinent to the area, I am interested in the means of lessening food poisoning and food infection by the toxigenic staphylococcus, the infectious Salmonellae, and other microorganisms of lesser frequency and pathogenicity. I am also interested in solving the problem by every means available—by attempting the application of our scientific knowledge, through education, regulation by codes and ordinances, by development of better food equipment and by better processing and handling of perishable foods that sustain bacteria and serve as good sub-strata for their growth.

I do not propose to discuss pathogenicity, invasiveness, toxicity, nor the symptoms indicative of each organism, or the behavior of these organisms in food individually. I am interested in discussing the fact that while the incidence of preventable diseases has been steadily decreasing, the incidence of food poisoning and food-borne infections has remained at approximately the same level during the past decade.

Food-borne intoxications and infections are reportable in most states; however, only the large outbreaks are thoroughly investigated and reported. Many small outbreaks are never reported. Accordingly, the U. S. Public Health Service can list only a small percentage of the outbreaks and cases. An estimate, based on the reporting of perhaps 10 per cent of the cases, would yield a figure of one million cases a year, an astounding morbidity rate of 570.

Other environmentally spread diseases have been controlled: for example, typhoid fever. In 1900, this disease showed a mortality rate of thirty-six. The disease was spread primarily through sewage-contaminated water, although food and milk were also carriers. In 1913, in this state, we started eliminating sewage from our water supplies by building water purification plants and training people to operate these plants effectively. The program was slow, because we had to develop means of purifications, develop techniques for evaluating the sanitary quality of the water, and develop means of training people to become operators. The tempo of activity gradually increased until after World War I, when the push for safe water began in earnest. Today the incidence for the United States is less than 0.2 and last year there were eight cases and no one died in Michigan from typhoid fever. Our water supplies in Michigan are safe. The fight to stop typhoid fever has succeeded, and this disease is a closed chapter, just as long as we continue to close all avenues of infection. The organism is still present in the sewage of our cities, so control must be continued, and just so long as regulations are maintained, the disease is under control. We have isolated the typhoid bacillus from East Lansing sewage and the Red Cedar River that flows through our campus, still we have no known carriers. I have always been curious as to its source.

During this same period, when preventable diseases have been lessened markedly by improved environmental conditions, a vigorous sustained drive has been made to improve food processing and handling to reduce food-borne intoxication and infection.

We know how staphylococci and salmonellae are spread. We know how to prevent their multiplication in foods. We have all the technical information that is needed to control these diseases, and still, we have not succeeded in reducing the incidence appreciably.

True, our population has increased and more people eat in public food establishments. In 1955, the National Restaurant Association reported the following kinds and numbers of eating establishments:

Restaurants, cafeterias, lunch counters, et cetera	194,123
Industrial restaurants	26,261
Hotels	15,100
Hospitals	6,572
	242,056

We spend nearly $17 billion annually for foods and beverages outside the home. An average of 78 million meals are served daily in our varied food service establishments. Our health agencies are reporting outbreaks regularly, so it may be argued that incidence appears high only because more cases are recognized. This may be true to a degree, but if our methods of control were effective, a marked decrease should occur.

From the Department of Microbiology and Public Health, Michigan State University, East Lansing, Michigan.

To date, the approach on disease control in food service establishments has been largely a regulatory inspection based on a code and ordinance of required specifications and operations, subject to license. The inspection is devoted primarily to the physical aspect of the establishment. Although an educational program is frequently used, it consists of a series of two or three night lectures crammed with the "do's and dont's" of food handling presented to the employees. At a completion of attendance, each attendant is rewarded by the issuance of a food card attesting his accomplishment of being present. He is now a full-fledged member of the fraternity with all the rights thereof.

The current U. S. Public Health Service Ordinance and Code Regulating Eating and Drinking Establishments which serves for the regulation of interstate food establishments and as a model code for states and cities, stresses the physical aspects in keeping with the inspection procedure. It is an engineering approach to a biological problem with little consideration of the biological aspects.

For example, the first item listed in the code is floors. "The floors . . . shall be of such construction as to be easily cleaned, shall be smooth, and shall be kept clean and in good repair." The health reason—"clean floors are conducive to clean food-handling methods."

The second item is "walls and ceilings." Walls shall be kept clean, kept in good repair and shall be finished in light colors. The health reason is the same.

The items continue on the theme of good construction, easily cleaned and clean, up to item 16—"cleanliness of employees." "All employees shall wear clean outer garments and shall keep their hands clean at all times while engaged in handling food, drink, utensils or equipment. Employees shall not expectorate or use tobacco in any form in rooms in which food is prepared."

In reading the Ordinance and Code, the impression could well be that a physically clean restaurant is an assurance that staphylococci and salmonellae outbreaks could not occur. The sanitarian or inspector making the inspections may give this impression unknowingly, and the operator may very likely believe that physical cleanliness of the establishment meets all requirements and the public is properly protected.

Through the code that accompanies the Ordinance are many "do's and dont's" of food handling, so items of biological significance are presented but the emphasis of examination is the physical structure.

In all fairness to the sanitarian and the ordinances, improvements in food service have been made in cleanliness, better equipment and ease of operation, but the glaring fact remains that the objective of the whole program—the elimination of disease transmission by food has not been accomplished.

Paradoxically, most of the outbreaks occur in the better restaurants, where clean operation is maintained. It becomes apparent that cleanliness *per se* is not the answer. Obviously, no one would defend the thesis that cleanliness is not, in part, an answer to good disease control.

If our present methods are not the answer, then we need a "New Look." The "New Look," in a sense, is a re-evaluation of objectives. What are we attempting —aesthetics—a pleasant place to eat—or public health —a safe place to eat? As health officials, the latter should be our objective; the former is the job of Industry.

Before setting regulations, the sources of the disease organisms should be considered. The toxigenic staphylococci are carried by personnel, who are in contact with the food. Boils, abscesses, throat and nose infections, or carrier states are the main sources of infection. The salmonellae may be found in intestinal discharges from infected persons or carriers, as well as in meat, poultry, eggs and dairy products.

Thus, personnel becomes the most important factor in disease spread and personal hygiene rates the first major step in a control program. Next, personnel must be trained in the handling and processing of food, they must understand the hazard of careless food handling, they must know the steps necessary to avoid food contamination and the means of controlling microbial multiplication.

Often in discussing food sanitation before health organizations, I have made the statement that 99.9 per cent of the problem is personnel. I have also stated that if anyone objects, I would be glad to argue a percentage of 99.999.

Personnel is thus more than employees who wear clean outer garments, who have clean hands, and who do not smoke or chew tobacco while working.

The job of disease control is not just a plant inspection—it is an educational project that must be planned carefully and executed in a manner that will train operators, particularly owners and managers, comparable to that attained in training water plant operators and dairy pasteurizers and bottlers.

On the premise that the causative organisms come from personnel and food, then the second item in a control program should be food quality. Meats from inspected packing plants, sea food from areas not con-

taminated by sewage, pasteurized milk, and poultry from inspected plants should definitely be required for public food service.

Salmonellae are frequently carried from the animals' intestinal tract to the carcass, through careless handling in the process plant. Federal, state or municipal inspection does not necessarily eliminate the presence of these organisms, but good plant sanitation and handling lessens the incidence. Inspection would also lessen the possibility of trichinosis, tuberculosis and other diseases transmissible to man from animal. In somewhat like manner, sea food gathered from unpolluted waters would be less likely to harbor the typhoid bacillus, the dysentery bacillus and other disease organisms, both bacterial and viral, that are carried in sewage. Comments on pasteurized milk are unnecessary, because only pasteurized milk is allowed in all food establishments.

The third item responsible in avoiding food poisoning and infection should be proper refrigeration. It must be remembered that in both staphylococcus poisoning and salmonellosis, the organisms must multiply in the food to high populations. This means that the temperature of food storage must be favorable to the microorganism, so that generation rates are high. Inasmuch as the food handlers have no idea of the presence of these organisms, or the degree of contamination, food should always be held at a temperature unfavorable for multiplication, where generation rates are exceedingly slow.

Present codes and ordinances specify a storage temperature of not to exceed 50° F. This temperature was set many years ago, when ice refrigeration was common, and it was impossible to attain temperature much below this figure, except in commercial storage houses, Foter and associates of the USPHS have demonstrated that salmonellae and staphylococci will grow at temperatures down to approximately 42° F. This means for extended storage, perishable foods in which these microorganisms can grow should be stored at a temperature of not to exceed 40°F.

In our present codes, we are concerned in refrigeration with checking air temperatures of the refrigerators, and looking for dirt and spoiled foods. In the "New Look" we, of course, check for these points, but we are more concerned in the use of the refrigeration; the size of the storage unit, the protection of the product by covers, and the period of storage.

Most epidemics are tied closely with personnel and refrigeration. Turkeys are responsible for more outbreaks than any other food. It is a large package, that takes a long time to cook, and a long time to cool. Generally, the turkey is stuffed with an insulation material, consisting of bread fragments, chopped liver and other food stuffs, that favor the growth of these organisms. Sometimes the cooking time does not allow the development of lethal temperatures in the stuffing and so the contamination persists and multiplication takes place even with refrigerated storage. Cooling is slow and bacterial multiplication occurs because of the large package. To avoid the disease hazards of roasted turkey, the turkey should be split in two, so baking can be faster and complete. Stuffing should be baked in a separate pan. If the food is to be stored at refrigeration temperature, the cooling is rapid, and little, if any, bacterial reproduction takes place.

The turkey is a good illustration of a package difficult to refrigerate rapidly. The operator should be vitally concerned with rapid cooling, and so the control of food poisoning and infection lies in proper refrigeration, the proper size package, proper circulation, refrigeration capacity and period of storage.

Along with refrigeration, of course, is cooking. Foods must be cooked at a temperature such that lethal temperatures for pathogenic bacteria result in all areas of the cooked food. Cooking is not always the final means of eliminating health hazard, as the toxin of staphylococcus is thermostabile.

The fifth factor in the "New Look" program is contact surfaces. Contact surfaces include all surfaces that come in contact with food products during the course of preparation and serving. Outbreaks of salmonellosis have resulted from placing cooked chickens on tables previously used for uncooked chicken contaminated by salmonellae. Here the program consists of presenting specifications and methods of cleaning and sanitizing.

These five factors are the key to a good program in preventing food-borne disease in our public eating places. The "New Look" is a plan to emphasize those factors directly responsible for causing or abetting food poisoning and infection. It is a plan of action carrying a minimum of minutiae. It is not an easy program to activate and maintain, but a plan that should pay dividends in disease prevention. At least, it is a new plan predicated on education and consideration of biological aspects of microbial disease transmission, and control of microorganisms.

This plan will be used in the development of the new USPHS Code and Ordinance. Every physician is invited to help in promoting better and safer food services in our restaurants.

Guest Editorial

Wilfrid Haughey, M.D. "A Distinguished Editor"

THIS ISSUE of THE JOURNAL, planned for more than a year to emphasize medical writing, has dual objectives: in addition to presenting a series of papers on several aspects of medical writing by members of the Michigan Chapter of the American Medical Writers' Association, it honors Wilfrid Haughey, dean of editors, practicing physician, otolaryngologist, medical statesman, citizen of Michigan and of Battle Creek. The Michigan Chapter of AMWA is glad to join the Board of Trustees of MSMS in honoring Wilfrid Haughey, whose picture is on the cover of this issue of THE JOURNAL.



WILFRID HAUGHEY

MICHIGANITE by birth and by breeding, Wilfrid Haughey was born in 1880. Following elementary and secondary schools education in Battle Creek, he had his pre-professional education at the University of Michigan and his professional education at Detroit College of Medicine, now Wayne State University College of Medicine, where he received his doctorate in medicine in 1906. After internship, followed by residency in Chicago Eye, Ear, Nose, and Throat Hospital, and by post-graduate work at Harvard Medical School, he served his country as a medical officer: he was a Lieutenant-Colonel in the United States Army Medical Corps, with the assignment Chief of Ophthalmology and Chief, Head Surgery, Base Hospital 36, France.

* * *

NOW IN HIS eighty-first year, Doctor Haughey is actively in practice and serving as Attending Ophthalmologist and Otolaryngologist in the Community Hospital in Battle Creek. He has served as Consultant to the American Legion Hospital, as Chief of Ophthalmology and as a member of the Executive Board of Leila Y. Post Mongomery Hospital, and he continues to serve as Consultant to the Veterans' Administration Hospital, all in or near Battle Creek.

Long an active member of MSMS and for nearly twenty years editor of THE JOURNAL, he has served as Chairman of the Board of Michigan Medical Service. He has long been a Fellow of the American College of Surgeons, and active in other professional organizations including the American Medical Association, the Calhoun County Medical Society, the American Academy of Ophthalmology and Otolaryngology, and the American Association of Railway Surgeons. In 1960, Doctor Haughey was elected Fellow of the American Medical Writers' Association; and he has been an active member of the Michigan Chapter of AMWA during that organization's four years' existence.

* * *

THE SOCIETY AND THE CHAPTER honor a distinguished editor, an outstanding physician, a prominent citizen . . . Wilfrid Haughey of Battle Creek, Michigan.

—J. P. GRAY, M.D.

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Reading, Writing And Rewriting

Medical writing cuts across many disciplines, for the elements of good writing come from various sources and are inherent in much of the literature of the world. There are examples of superior writing from nearly all peoples and in all languages.

Some critics have said that medical writing is not as good as it should be because it lacks some of the human touch that tends to make reading interesting. It may be that in becoming more scientific and more exact, it loses some of its warmth. Generally it lacks expository references to the allied sciences and to the classical knowledge of the non-medical world. Perhaps it is narrow writing for narrow reading.

Medical writing calls for considerable confidence based on extensive knowledge and familiarity, preferably through personal experience and observation, with the particular data under consideration. Writing ability is enhanced by a background of extensive reading in general literature, in science, and in the classics. Homer, Plutarch, Cicero, Hippocrates, Voltaire, Bacon, Shakespeare, Spencer, Newton, and many others should be familiar to the writer. Great readers often become fine writers.

Duty drives some of us to read unattractive material on the premise that it must be good for us and because we need to know something about the particular subject. Bitter medicine has been prescribed on the same basis. If an author who has something to say because it interests *him*, can say it well, and quits when he has done so, he will have accomplished much. Unfortunately, some authors have written without fulfilling these criteria.

Most writers in medicine set out to describe some new observation, or procedure, or to present little known information. His presentation should flow evenly and develop his thesis in logical sequence. The material should proceed from the familiar to the unfamiliar. New statements should be relevant to previous assertions, as the evidence is presented leading to the conclusion for which the paper has been written, the climax.

Medical writing cannot always be simple; but it can be clear, concise and consecutive. It cannot always be colorful; but it can be precise, pertinent and purposeful. It cannot always herald a brilliant new discovery or concept; but it can be accurate, descriptive and observational. It cannot always be free from technical words and ideas; but it can be free from verbosity, split infinitives and dangling participles.

Putting the conclusion in the first paragraph may be suitable for journalists, but it is not justified in medical writing. Short clear sentences, with a minimum of punctuation, generally read more easily than those containing interpolations, quotations, or parenthetical statements.

The most important factor in any kind of writing is clarity of expression. Style is largely a matter of personal inclination and preference. Great help can come from experience through frequent reading, continued writing and rewriting.

Easy reading is hard writing.

CHARLES SELLERS, M.D.

Medical Writing

This issue of THE JOURNAL of the Michigan State Medical Society is devoted to Medical Writing and to the Michigan Chapter of the American Medical Writer's Association. The assignment and programming to produce this number of THE JOURNAL has been in process for over a year.

J. P. Gray, M.D., of the Parke-Davis staff, is responsible for the suggestions and the carrying through of the planning. Members of the Association and others were asked to provide papers which could be used in this issue of THE JOURNAL. These papers were written many months ago and submitted to a committee consisting of Dr. Gray, Charles Sellers, M.D., Detroit, and S. J. Houtz, R.N., Detroit, who reviewed them at a special meeting, did some editing, and had them retyped and prepared for the printer. They did a thorough and wonderful job.

Why select Medical Writing for an issue of THE JOURNAL? For the very good reason that the vast majority of medical communications, training, instruction, not to exclude records and the distribution of new knowledge, must come through the printed page. The American Medical Writer's Association has selected this aspect of medical communication as its particular bailiwick. It is often a discouraging task to induce a doctor to write a paper for presentation or for publication as we have found in years past. We believe, however, Michigan is well advanced in the area of medical writing, but we know how difficult the task is for some.

Just recently one of our prominent surgeons was bemoaning the fact that doctors, in spite of their elaborate preparation in premedical work, are loath to write anything. We are very happy to present this unique effort in medical journalism.

Editorial Writing

Writing of editorials is an especially challenging and exacting part of the field of medical writing. During the years, THE JOURNAL of the Michigan State Medical Society occasionally has published a scientific editorial other than those in connection with the

special topic or area to which the particular number of THE JOURNAL is devoted. In general, scientific editorials demand a man of broad experience, a judicial character with an appreciation of the whole subject, and an ability to express himself well. That type of editorial writing is used on occasion but is limited largely to the specialty and special interest journals.

In a sense, THE JOURNAL of the Michigan State Medical Society is a trade journal. Its function is to pass on to the membership the scientific advances, administrative and other programs, news items of interest, comments, and enough material of various types to keep the readers interested. It has another function which is to interpret to the membership the philosophy, the goals, the accomplishments, and the socio-economic problems which involve the profession. This also demands a special type of editorial writing. It requires an intimate knowledge of what is transacting, of the problems to be met, the accomplishments which can be reached, and the means by which these ambitions may be attained.

The Editor must be able to select the timely and significant socio-economic or other items most important to the profession. In order to do this, he should personally or through contact, be more or less in complete touch with the working of the various and sundry groups which are responsible for the administration of the affairs of the society. This type of editorial has a policy-making bearing whether signed or not. It has been the policy of the present Editor, therefore, since he took office, to make a preliminary preparation of his editorials. About the second or third going over, he sends a mimeographed copy to each member of the Publication Committee and other policy-making officials of the State Medical Society, including the immediate Past President, the President-Elect, the President, the Speaker and Vice Speaker of the House, the Chairman and Vice Chairman of The Council, the Secretary, the Executive Director, the Public Relations officer, the President and Director of Michigan Medical Service and our Attorney.

These men are asked to make corrections or additions, or to suggest other and different editorials. In selecting this advisory group, the Editor knows that a large group of well-posted officials have read his editorials and if they do not comment, they have by acclamation approved them. The final form of the editorials, incorporating any suggested changes, is then made up and sent to the editor.

THE JOURNAL occasionally also uses a guest editorial. Whenever any of our members has an inspiration to write an editorial which he will sign, we are happy to consider it, the restriction being that if it is controversial, we have someone prepare a response to be published simultaneously. That has been done several times in years past.

Medicine and Legislation

There are many problems which need the attention of our friends in the legislature. The medical profession should grasp every opportunity to accomplish some of them. A compelling fact is that relief agencies, welfare agencies, and the government, notoriously underpay the doctor and the hospital for their services. Many years ago, the Michigan State Medical Society House of Delegates expressed the conviction and belief that patients who are the medical and health responsibility of governmental departments, cease to be indigents. Under the old philosophy, they were "our" responsibility and the medical profession cared for them for nothing or token fees.

The State clothes them, feeds them, gives them shelter, so it should also provide health services. The law sets up some limited rates for hospital payments and payments for doctors which are ridiculously inadequate. Our Michigan State Medical Society House of Delegates in the September 1960 meeting adopted a resolution calling upon the various component county and district medical societies to review the compensation rates with their state, county and local officials and bring them up to date. Until recently one stumbling block has been that the state was broke and didn't have the money, but now two occurrences relieve that situation.

The Kerr-Mills Bill (also called AMA) enacted by the Federal Congress provides a means of taking care of the senior citizens of inadequate income who need assistance through combined state and federal general tax funds. This program is in successful operation. It provides that for local areas, counties, etc., the state and federal combined authority will pay 90 per cent of the local charges, thus relieving the county and local welfare departments of the heavy charges they have complained about. There is now no reason why our county welfare officers should refuse to meet reasonable charges such as those contained in The Fee Schedule for Governmental Agencies, dating back over a period of years and published by the Michigan State Medical Society. The local agency will now pay only 10 per cent of the bill instead of from 50 to 60 per cent as it did up until now.

Also, the Michigan Legislature in its special session acting upon the vote of the people, authorized an increase in the sales tax, thereby putting the state back into the solvency column. The state cannot waste money, but paying the actual cost of hospital beds and services, and a minimum cost for medical and surgical care is a duty and responsibility and not a luxury.

The MSMS House of Delegates urges these conferences with the responsible agencies and officials and

The Council has passed on that information to the various counties. All these county and district societies should act immediately because there are certain provisions in some of the laws by which certain of the state agencies are limited in the amount they may pay for services or accommodations, specifying that they will not pay more than other governmental agencies. For instance, the Crippled Children Commission may not legally pay more for certain services than the welfare commission does in that county or district. This situation is ridiculous but true. Each agency should pay an adequate amount but neither should be limited by what the other may do in any particular area.

Federal Programs

One of the most important items in the recent political campaign was the care of the aging—the over-65 person who is a beneficiary of the social security program. It was proposed to give them their health services under social security (Forand type plan) and President Kennedy in his campaign, promised he would bring this about. His agitation and his threat to put health services under social security stimulated the so-called Kerr-Mills Bill. This was enacted instead of either the Forand type legislation or the plan advocated by former Vice President Nixon. This Kerr-Mills program is now in operation. It has its imperfections but it can be made to work. It MUST be made to work.

At its interim session in Washington, November 27-December 2, the AMA devoted untold hours of study, planning and conferences to evolve a program for the aging (over-65 person) whose income is limited. The most important result was a reconfirmation of the medical profession's belief in and devotion to Blue Shield and Blue Cross type protection. It was expressed repeatedly that such a program, with the cooperation of the AMA and the American Hospital Association, could provide the needed services if only allowed to do so.

All interested personnel must realize that if this essential program fails, and medical care is placed under social security, it will spell the end of the private independent practice of medicine, as we have known it. It has ceased to be a case of waiting until one can make a little change here and another there, with neither going forward toward the grand objective and accomplishing the complete goal. Medicine must first save the basic program, then make such minor or major changes as are needed after the basic program is working efficiently.

The philosophy of let's work now and solve the differences later was almost universally expressed.

The McNerney Report

Professor Walter McNerney of the University of Michigan gave a talk on "Medicine and Hospitals in Michigan" at the 1961 Annual County Secretaries, Public Relations Seminar. He devoted his talk much more to hospitals than to medicine, the hospitals being in much more difficulty than the medical profession. He compared the cost of living rate increase based upon the Chamber of Commerce 1948-9 as 100, which has gone up 24 per cent.

He reminded his audience that labor for the restoration and preservation of hospitals has gone up 90 per cent, due to increased costs of wages and salary and to increased usage of many expensive utilities and extension of service rendered. In the medical end, the increase has been 39 per cent *in toto*, due also to the very rapid extension of possible facilities, entering new fields and rendering services unheard of ten years ago. He stated that increased costs for surgery have been 23 per cent against a total cost of living of 24 per cent. When broken down into items, the medical profession has done an acceptable job, comparing the extended services now given with the very limited service of ten years ago.

He mentioned that the medical profession had done a job in making health services available to patients by setting up a program whereby health services are available through a regular contribution. Blue Cross and Blue Shield give subscribers services rather than money. This program is here to stay. It cannot be discontinued because it has grown into the economy and people are now demanding services. Labor is increasing its demand that management take over the premiums for the various insurance programs. More than 70 per cent of the hospital bills in Michigan are now being paid through insurance, Blue Cross, or numerous insurance companies. In medicine, that figure is only 19 per cent, and that service must be extended if the public is to be satisfied.

Caring for these people through the insurance principle is firmly established, and the medical profession which established this principle must see to it that it does not fail else this program will of necessity go to the government. Professor McNerney said that our basic principles are correct, but within our own ranks, we must adjust our minor internal differences of opinion. He said the medical and health professions have the ability and mechanism to provide top quality health services to patients in Michigan by united effort.

Ribicoff Directs HEW

Abraham Ribicoff, former governor of Connecticut, is the new Secretary of Health, Education and Welfare, appointed by President Kennedy to succeed Arthur S. Flemming.

The 50-year-old governor, an early supporter of Kennedy for the nomination, made a national reputation for inaugurating a comprehensive traffic safety program with strong penalties.

A graduate of the University of Chicago law school, Secretary Ribicoff has served as a Hartford, Conn., police judge, a member of the state legislature, a member of Congress. He was elected governor twice.

Mr. Ribicoff was one of 23 governors who signed a telegram to the Senate Finance Committee last session urging enactment of a Social Security health care program for the elderly.

As HEW Secretary, Mr. Ribicoff will be the cabinet officer responsible for most of the Federal activities that involve the medical profession and public health, including the U. S. Public Health Service, the National Institutes of Health, the Social Security Administration, Food and Drug Administration, Office of Education, and Office of Vocational Rehabilitation.

Some $15 BILLION annually is distributed by HEW, with a large share being Social Security payments. The PHS budget is about $1 billion.

* * *

Doctors Serving Peace

The first team of medical volunteers is serving aboard the *Hope J* in Indonesia—serving on the front lines of peace in the new Project HOPE. Many others are all set to work their shifts and there is a waiting list of over 20 American doctors of medicine who have volunteered to serve.

Project HOPE is advancing plans now for similar projects for Africa and South America.

* * *

Doctor Bauer Named Consultant

Louis H. Bauer, M.D., former secretary-general of The World Medical Association, is a consultant now to that organization. A past president of the American Medical Association, he was secretary general from 1948 to 1960.

Heinz Lord, M.D., of Barnesville, Ohio, is the new secretary-general of The World Medical Association.

* * *

Directs AMA Council on Drugs

The American Medical Association has selected William C. Spring, Jr., M.D., Brooklyn, N. Y., as the new secretary of its Council on Drugs.

Dr. Spring, who holds degrees from Wisconsin, Duke, and Columbia universities, succeeds Harold D. Kautz, M.D., who resigned to accept a position with Abbott Laboratories, North Chicago, Illinois.

Dr. Spring comes to the AMA from Chas. Pfizer & Co., Brooklyn, where he had been serving as medical director of the laboratories division.



Berlin Industries Fair

By Philip Bockman

Of the 600,000 people who saw the 1960 Berlin Industries Fair in Germany, about 500,000 went through the United States exhibit. There they saw twenty-seven American teens and about thirty sons and daughters of U. S. Army personnel stationed in Berlin, all engaged in some type of "typical" American activity. There were girls modelling teen fashions, boys with "hot-rods" and go-carts, Boy Scouts with flapjacks, boys on the tumbling mat, girls displaying samples of American books, and people with exhibits of electronics, mathematics, space science, chemistry and medicine.

My exhibit, consisting of pictures and an x-ray, showed how I replaced a dog's Achilles tendon with an artificial tendon of stainless steel wire and polyethylene tubing and Ivolon. The Germans posed many questions about American medicine, medical schools, and research. Evidently their students, in medical school, must wait until nearly the end of their schooling to engage in work with live animals. In America our education is more clinical in nature.

Other scientific exhibits included an ultraviolet flying-spot electron miscroscope, a space-unit for survival on Mars, and a discovery of the effect of testosterone on the production of red blood cells—all demonstrated by the teenagers who made them.

We were in Berlin four and one-half weeks, working at the Fair nearly three weeks. We met Mayor Brandt and the Bundes President and many prominent German scientists, and they questioned us about all phases of American life. During the two weeks of the Fair's opening to the public, we had only a few heckling visitors; everyone was pleasant and interested. Some of us were invited to private homes in Berlin, and again we found the German people friendly and hospitable.

We returned to the U.S.A. with mixed feelings of hating to leave Germany and being very glad to be home. On behalf of all twenty-seven of us, I hope that we have created a favorable image of the United States—in medicine and other fields—in the minds of the German people.

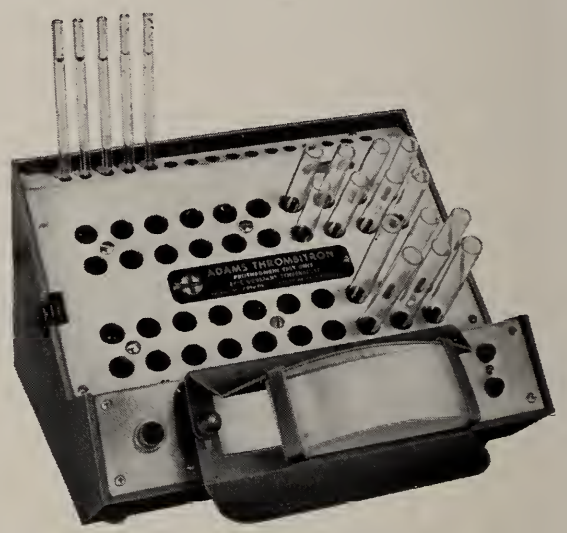
* * *

Philip Bockman is the young man from Grand Rapids who won the National Science Award last spring for his work on replacing a dog's Achilles tendon by an artificial tendon of steel and polyethylene tubing. He received a $1,000 check from the American Academy of General Practice to help him attend the World Youth Congress in West Berlin. He is now a freshman medical student at the University of Michigan.

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Elect New Leaders For Health Council

Sidney E. Chapin, M.D., Dearborn, assumed the presidency of the Michigan Health Council at the organization's recent annual meeting in Detroit. Officers and members of the Board of Trustees also were elected at the meeting, which was held in McGregor Memorial Conference Center.

William McNary, Detroit, executive vice president and general manager of Michigan Hospital Service, was named president-elect. Marvin L. Niehuss, vice president and dean of faculties of the University of Michigan, is the retiring president. Hugh W. Brenneman, MSMS public relations counsel, was re-elected secretary. L. Gordon Goodrich, executive vice president of Michigan Medical Service, was elected to succeed himself as treasurer. J. K. Altland, M.D., Lansing, was elected medical director and Harry B. Zemmer, M.D., Lapeer, continues as president emeritus.

Those re-elected to three-year terms as members of the Board of Trustees were Otto K. Engelke, M.D., Ann Arbor, MSMS president-elect; James H. Fyvie, M.D., Manistique; Mrs. Marjorie Karker, Lansing, Farm Bureau Women's Activities; Mrs. Grace Kistler, Grand Haven; Gordon H. Scott, Dean of Wayne State University College of Medicine; E. Gifford Upjohn, M.D., president, Upjohn Company; and Mr. Niehuss.

Twelve new member organizations and two new Associates joined the Health Council and received certificates at the Council's Annual Meeting December 8.

New voting members were: American Cancer Society, Southeastern Michigan Division; Alma College; Eastern Michigan University; Gerber Baby Foods Fund; Hope College; Michigan Association for Emotionally Disturbed Children; Michigan Cancer Foundation; Michigan Dietetic Association; Michigan Elks Association, Major Project Commission; Michigan Society of Gerontology; Wayne State University College of Pharmacy; and Western Michigan University. Organizations accepted as Associates were Ira Wilson & Sons Dairy Company and Mallard, Inc.

With the addition of these 12 voting members, the membership of the Health Council now stands at 93. There are seven Associates.

* * *

Heads Cancer Foundation

Rosser L. Mainwaring, M.D., of Dearborn, is the new president of the Michigan Cancer Foundation. He succeeds Howard P. Doub, M.D., Detroit.

Appointed as chairman of the Foundation's medical and scientific committee is Oscar D. Stryker, M.D., newly-elected vice-president and director of the Macomb County Health Department. Newly-elected trustees are Brock E. Brush, M.D., Dearborn; Joseph A. Witter, M.D., Highland Park; Gordon R. Maitland, M.D., Detroit; Gerald S. Wilson, M.D., Detroit, and Glenn W. Bylsma, M.D., Pontiac.



Other officers were re-elected, including Lyndle R. Martin, M.D., Detroit, as secretary.

Michael Boris Shimkin, M.D., Associate Director of the National Cancer Institute, was guest speaker at the dinner which followed the annual board meeting. He spoke on "International Aspects of Cancer Research."

Join MAP Meeting at Saginaw

Many doctors in the Saginaw area participated in the meeting sponsored recently by the Michigan Association of the Professions at the Rolling Green Country Club, Saginaw.

V. E. Cortopassi, M.D., was a member of the local committee which brought together more than 100 men in the professions of architecture, dentistry, engineering, medicine, law, pharmacy, and veterinary medicine, to exchange ideas on programs to advance professional ideals and interests and to learn more about the structure, projects and goals of MAP.

Plan Accreditation of Nursing Homes

Delegates to the American Nursing Home Association convention in Washington adopted a resolution that gives the green light to one of its special committees to work out the details of a plan for accreditation of nursing homes.

Calling for several levels of supervision, the ANHA accreditation program would be set up on a nationwide basis.

"My committee is ready with a program consistent with the progress our American Nursing Home Association has made," declares Elmer Kocovsky, M.D., committee chairman and president of the Wisconsin Nursing Home Association. "The demand from our membership is so great that it is imperative that we start on a program immediately."

In advocating an ANHA accreditation program, Dr. Kocovsky made it clear that its creation does not indicate any lack of interest in plans of the Tripartite Committee on Accreditation, consisting of representatives of ANHA, The American Hospital Association and American Medical Association.

Association of Blood Banks Holds Detroit Conference

The Michigan Association of Blood Banks held its annual meeting recently in Detroit. A comprehensive workshop in blood banking was held at Wayne State University Medical College while the scientific program was conducted at the David Whitney House. Numerous excellent speakers were included in the scientific program. This meeting was a part of the Continuing Education Program of the Michigan Association of Blood Banks which helps medical technologists and pathologists keep up on the latest developments in blood banking.

Invite Doctors to Attend Chamber Aircade in Detroit

The United States Chamber of Commerce "Aircade for Citizenship Action" will stop in Detroit March 1 to present a program—and Michigan doctors of medicine are invited to attend.

Doctors are encouraged to contact their local chambers of commerce, which are arranging motorcades and chartered buses to the Detroit meeting.

The Detroit program will begin at 9:25 a.m. at the Masonic Temple and will conclude at 3:30 p.m. The session will specifically cover medical care for the aged and other timely topics.

Arthur H. Motley, president of the U. S. Chamber and publisher of *Parade Magazine*, will head the Aircade team.

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(This column is sponsored by the Michigan Society of Obstetrics and Gynecology)

Evaluation of Maternal Deaths Due to Direct Obstetric Causes

*Michigan, 1950-57**

In the Michigan Maternal Mortality Study all maternal deaths are evaluated by the Central Evaluation Subcommittee of the Maternal Health Committee of the Michigan State Medical Society. This committee consists of the chairmen of the Departments of Obstetrics and Gynecology of the University of Michigan and of Wayne State University, the chairman of the MSMS Maternal Health Committee and the obstetric consultant of the Michigan Department of Health. Regional evaluation subcommittees have been established in Saginaw, Grand Rapids, Kalamazoo, and Lansing.

In the evaluation of maternal deaths, the Central Evaluation Subcommittee attempts to ascertain the cause of deaths by considering the clinical course of the case, the information provided on the death certificate, and the findings at postmortem examination, when these are available. The cause of death is then classified as due to a direct obstetric cause, to an indirect obstetric cause, or to an unrelated cause. A death due to a direct obstetric cause is one clearly resulting from the pregancy, as in hemorrhage, toxemia, infection, transfusion reactions, et cetera. A death due to an indirect obstetric cause is one in which the death was caused by some condition other than the pregnancy but which could have been aggravated by the pregnancy, e.g., cardiac, vascular, reproductive, tract, hepatic, pulmonary and metabolic diseases and others, such as appendicitis and sickle cell disease. Example of non-related causes are cancer, accidents, et cetera.

An effort is then made to decide whether factors of preventability were involved. It is attempted to be completely objective in this analysis and conclusions are reached without a knowledge of the area or hospital in which the death occurred, the name of the patient, or of the physicians in attendance. The data is studied to determine what factors may have contributed to the death of the patient—whether she failed to cooperate, or if there was an error in medical skill or judgment, or whether the hospital facilities (including laboratory services, nursing care or equipment), were inadequate. This is not to say that

TABLE I. MICHIGAN MATERNAL MORTALITY STUDY, 1950-1957
(Preventable Factors)

	Physician	Consultant	Patient	Physician and Patient	Physician and Consultant	Physician and Hospital	Physician Patient and Hospital	Hospital	Unpreventable
Abortion	3	0	41	0	1	0	1	0	0
Ectopic pregnancy	23	0	8	7	1	2	0	0	7
Placenta previa	12	0	0	0	3	1	2	1	4
Abruptio	9	0	2	0	2	2	0	0	8
Placenta accreta	0	0	0	0	0	0	0	0	2
Inversion uterus	3	0	0	0	0	0	0	0	0
Rupture uterus	55	0	0	3	7	2	0	0	5
Postpartum hemorrhage	42	0	2	2	2	5	0	1	11
Toxemia	51	2	12	26	1	1	0	0	28
Septicemia and peritonitis	19	1	3	0	2	4	0	0	9
Amniotic fluid embolism	0	0	1	0	0	0	0	0	14
Air embolism	0	0	9	0	0	0	0	0	1
Anesthesia	32	0	0	0	0	2	0	0	7
Afibrinogenemia	1	0	0	0	1	0	0	2	14
Transfusion misadventure	5	0	1	0	0	5	0	5	0
Total	255	3	79	38	20	24	3	9	110 =341

*Maternal deaths due to indirect obstetric causes will be discussed in a subsequent article.

the patient necessarily would have survived had these factors not been present.

Of the 987 maternal deaths in 1950 through 1957, 624 were due to direct obstetric causes, 252 to indirect obstetric causes and 111 to non-related causes. Of the 624 deaths due to direct obstetric causes, 110 were considered unpreventable. Preventable factors were found in the remaining 514 cases (Table I).

Medical factors alone were concerned in 278 cases. Patient factors, usually consisting of neglect to obtain prenatal care or submitting to criminal or self-induced abortion, or failure to follow medical advice, were present 79 times. Medical and patient factors were involved jointly 38 times; the physician and the hospital 24 times; the hospital 9 times; and the physician, patient and hospital 3 times.

Medical factors occurred most frequently in deaths from ectopic pregnancy, placenta previa, rupture of the uterus and postpartum hemorrhage, all classified as Hemorrhage. We are particularly concerned with this finding. In spite of the high rate of preventability, deaths from hemorrhage increased in the 1954 through 1957 period to 1.89 per 10,000 live births as compared with 1.70 per 10,000 live births in the years 1950 through 1953. The preventable factors were usually: deferring examination of patients with ectopic gestations until the bleeding ceased or postponing operation after making the correct diagnosis to await improvement in the condition of the patient; examination (vaginal or rectal) of patients with placenta previa without preparation for transfusion and immediate cesarean section; rupture of the uterus after prolonged labors in grand multipara with malpresentations or traumatic deliveries (version and extraction or difficult forceps procedures) through an incompletely dilated cervix, or the antepartum or intrapartum administration of pitocin without regard for contraindications or the observance of all requisites.

In 26 deaths from toxemia, the patient had failed to seek prenatal care and in many of these instances was already eclamptic when admitted to the hospital. Where medical responsibility was involved, it was usually due to failure to hospitalize patients with signs of impending toxemia, or induction of labor before the patient had been stabilized.

Maternal mortality in Michigan will be reduced by:

1. Early and regular prenatal care, which should be started as soon as pregnancy is suspected.
2. Examining all patients at the first prenatal visit regardless of bleeding.
3. Early consultation in all complicated cases.
4. Prompt operation while replacing lost blood after ectopic pregnancy is recognized.
5. Avoiding vaginal or rectal examinations until preparations for cesarean section have been made and blood is made available in painless bleeding in the last trimester.
6. Replacing lost blood in abruptio placenta and checking fibrinogen concentration, and unless indications of early vaginal delivery are present, delivering abdominally.
7. Avoiding version and extraction except for the second twin. Using forceps as a trial procedure.
8. Restricting antenatal pitocin administration to carefully selected patients and observing all contraindications and requisites.
9. Re-evaluating all cases of prolonged labor by x-ray examination and consultation.
10. Having compatible blood available for every delivery.
11. Exploring the pelvis when bleeding is excessive.
12. Hospitalizing and stabilizing patients with toxemia.

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MICHIGAN DEPARTMENT OF HEALTH
ALBERT E. HEUSTIS M.D., State Health Commissioner

Highlights 1960—Part Two

Last month, we highlighted some of the laboratory services of the department. This month, we review some of the activities in the field of mass screening examinations.

As we have said before in these pages, we know that the early detection of many diseases can and does save lives and prevent serious disability. Therefore, we believe there is a vital need to use the proven early detection weapons we have on a much larger scale. Such screening programs are aimed at getting the person with possible disease to his physician for diagnosis as soon as possible, when the chances for correcting or alleviating the condition are best.

During the past year, a number of screening programs were conducted to detect possible tuberculosis, heart disease, cancer, venereal disease, glaucoma and diabetes.

Tuberculin Skin Testing

More than 442,000 persons were screened with the Mantoux test in 42 counties. This was an increase of 51 per cent over those tested last year. About 94 per cent of those tested were school children. Among these children, 1.3 per cent were reactors as compared with 1.7 per cent in the approximately 280,000 tested last year.

Chest X-ray

A total of 292,102 chest x-ray screening films was taken in surveys in 57 counties. Of these, 12,598 showed some chest abnormality; 4,265 showed suspected tuberculosis, including 1,367 active or probably active; 4,173 showed suspected heart disease; 481 showed suspected lung cancer; and 3,782 showed other chest pathology.

In addition, 6,947 follow-up 14 x 17 x-ray films were taken in 37 counties.

Diabetes

Diabetes continues to be the sixth leading cause of death in Michigan, taking 1,715 lives in 1959. It is also the third leading cause of blindness. Over 26,500 persons were screened for diabetes in 1960, with 313 revealed as diabetes suspects. Diagnostic returns are not complete, but so far 89 new cases have been diagnosed, 22 old cases brought under supervision, and 22 diagnosed as not presently diabetic but with regular checkups advised. Five new Glover-Edwards Diabetes Test Kits were secured late in the year and are now being set up in five areas in the state where small scale regular diabetes screening operations will be carried on.

Cancer

Over 4,000 women were examined for possible cervical cancer in screening programs. While diagnostic findings are not yet in for all the women who were found to be cancer suspects, 15 cases have been definitely diagnosed. These preliminary findings give a rate of 2.8 cancer cases per 1,000 examinations.

Glaucoma

In two counties, 2,044 persons were screened for glaucoma, the second leading cause of blindness. Of these, 61 had a positive test and 10 were diagnosed as glaucoma. No glaucoma was the diagnosis in 23, 15 others were questionable and being followed by ophthalmologists. The remaining 13 had not had all tests needed to make a diagnosis.

Venereal Disease

Reported cases of primary and secondary syphilis in Michigan showed a decided jump. There were 146 cases in 1959-60 compared to 79 cases in 1958-59, or an increase of 85 per cent.

During the year there were 33,469 blood tests for syphilis done in surveys. As a result, 344 persons were either brought to, or returned to, treatment. Clinics throughout the state carried out 21,442 diagnostic observations for venereal disease and 8,663 persons were treated.

New Address

As of December, the staff and offices of the Division of Hospital and Medical Facilities have moved from their previous location in the Bauch Building, Lansing, to the first floor of the Administration Building of the Michigan Department of Health, Old DeWitt Road, Lansing 4, Michigan.

Available only to physicians for their distribution—

Complete Cholesterol Depressant Menus and Recipe Book

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Now available for use in your practice from The Wesson People . . . easy-to-use manual of 40 pages, including all necessary diet instructions . . . menus, recipes, shopping and cooking guidance . . . all worked out for you . . . so arranged and printed that you have only to check the desired daily calorie level before giving the book to your patient.

You will find this book invaluable for treating patients with elevated serum cholesterol.

Complete menus for 10 days enable you to prescribe diets which are appetizing, nutritiously adequate and which can exert cholesterol depressant activity. Special attention has been given to constructing the menu patterns so that they adhere as closely as permissible to the patient's normal eating habits.

NRC Standards fulfilled. Each menu has been calculated to provide the proper daily allowance of proteins, vitamins and other nutrients as recommended by the Food and Nutrition Board of the National Research Council.

Weight control is achieved as each day's menu is given at 3 calorie levels—1200, 1800 and 2600 calories. You prescribe the level most desirable and modify as desired.

Variety and appetite appeal for patient are built into the menu plan to an extent not previously accomplished. Alternate choices for main dishes minimize monotony, encourage the patient to follow closely the menu plan you specify.

Complete recipes—65 in all—are included to assure that the specified menus provide prescribed levels of calories, the pre-determined ratio of poly-unsaturated to saturated fat, plus essential nutrients.

Dietary fat is controlled so that approximately 36% of the total calories are derived from fat and at least 40% of these fat calories are from poly-unsaturated components (linoleates) as found in pure vegetable oil. The replacement of saturated dietary fat by this percentage of poly-unsaturated fat has been found in clinical studies most effective in the reduction of serum cholesterol and in its maintenance at desirable levels. More liberal menus are provided for maintenance after the patient's progress indicates that desired therapeutic results have been accomplished.

Family meal preparation is simplified. The menus are planned around favorite foods having wide appetite appeal for all members of the household. Patients can entertain in comfort—enjoy cakes, cookies, snacks, prepared with recipes which meet medical requirements.

A high degree of satiety is achieved even at the lower calorie levels, because Wesson provides an unexcelled source of concentrated, slow-burning food energy.

Adaptable for use with diabetics. Carbohydrates have been calculated to fall within the acceptable range for patients to whom a diet planned for diabetes is important. Calories, which must be supplied from fat when the carbohydrate intake is limited, are provided by desirable poly-unsaturated vegetable oil.

WESSON'S IMPORTANT CONSTITUENTS

Wesson is 100% cottonseed oil—winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
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Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (Predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free

Poly-unsaturated Wesson is unsurpassed by any readily available brand, where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen.

Brief and to the Point

FLINT SURGEONS ELECT—The Flint Academy of Surgery, at its annual meeting, installed Harold W. Woughter, M.D., as president for 1961 and named Donald R. Wright, M.D., as president-elect. Also elected were Richard L. Rapport, M.D., secretary-treasurer, and Russell C. Sandberg, M.D., corresponding secretary. Dr. Woughter succeeds William P. Boles, M.D.

* * *

ADVISORS HONORED—Three veteran medical advisors of Dickinson County were recognized for their long service to the Dickinson Selective Service board at a meeting of the Iron Mountain Rotary Club. Honored were W. H. Alexander, M.D., W. H. Huron, M.D., and D. R. Smith, M.D.

* * *

APPRECIATION VOICED—The Ottawa County Selective Service presented pins and certificates of appreciation for 20 years of service to the draft board by three Ottawa doctors of medicine. Honored were Edwin Vander Berg, M.D., and H. J. DeVries, M.D., both of Holland and C. E. Boone, M.D., Zeeland.

* * *

HONORED BY STATE HEALTH OFFICERS—John D. Monroe, M.D., director of the Oakland County Department of Health, was presented with a distinguished service award by the Michigan Health Officers Association.

Formal presentation of the award was made during the December 2 meeting of the Oakland County Board of Supervisors.

In point of service, Dr. Monroe has been a health officer longer than any other Michigan health officer. He has served since Dec. 31, 1926.

He was instrumental in organizing the Oakland County Department of Health, the first in Michigan. Now 65 of the 83 counties are served by health departments.

* * *

RECEIVES GRANT—Seventeen research grants of the Tobacco Industry Research Committee includes one to Edward F. Domino, M.D., Ann Arbor. He is studying the "Effects of tobacco smoke and nicotine on the central nervous system." The Committee made 57 grants to scientists in 1960 for a total of nearly $800,000.

* * *

EXAMS SOON—The American Board of Obstetrics and Gynecology will conduct oral and clinical examinations (Part II) at the Edgewater Beach Hotel, Chicago, April 8 through 15. Current Bulletins of the American Board of Obstetrics and Gynecology, outlining the requirements for application, may be obtained by writing to Robert L. Faulkner, M.D., Secretary, 2105 Adelbert Road, Cleveland 6, Ohio.

Contributions for this "News Brief" department are invited from individual physicians, from county societies, and from other health organizations. Please direct your contributions to the Editor.



ENDS PUBLICATION—*The Armed Forces Medical Journal* with the December 1960 issue ceased publication. It has been published for 11 years, representing the three branches of the Department of Defense and printed in the United States Government printing office. There has been no advertising. It has been an excellent medical journal with a few short editorial comments. It is hoped much of this material will appear in *Military Medicine*, published by the Association of Military Surgeons.

* * *

STARTS PUBLICATION—*The Journal of Surgical Research*, a new medical journal, is announced by the W. B. Saunders Company.

The Journal of Surgical Research will carry no advertising, will have no set size, and will appear early in 1961, possibly May.

Michigan is especially interested because the editor will be Charles G. Child III, M.D., Ann Arbor, and the Assistant Editor is George D. Zuidema, M.D., also of Ann Arbor.

* * *

SOCIETY ELECTS—Officers of the Western Michigan Pediatric Society for 1960-1961 are as follows: president, S. Sprigg Jacob, M.D., East Lansing; vice president, Jerome E. Webber, M.D., Grand Rapids; secretary-treasurer, Marshall J. Feeley, M.D., St. Joseph; assistant secretary-treasurer, John L. Doyle, M.D., Grand Rapids.

* * *

REPORTS EXPENDITURES—Figures provided by the National Foundation for campaign efforts during the past 23 years in Michigan reveals that $18,125,791 have been available to Michigan county chapters, and grants of $4,066,908 have been made to Michigan institutions for research and educational projects. Funds also have been spent, according to the report, for vaccine field trials, salk vaccine and gamma globulin.

* * *

U-M COURSES—Several postgraduate courses are on the calendar at the University of Michigan during the next several months. Slated for the U-M Medical Center are Psychiatry, February 20-21, Electrocardiographic Diagnosis, March 27-April 1, Diagnostic Radiology, April 3-5, and Endocrinology and Metabolism, April 17-21, 1961.

* * *

MEDICAL TELEVISION SHOWS—The Michigan Health Council reports that the following topics were covered during the month of December on the weekly Sunday morning program over WJBK-TV, Detroit: Cerebral Palsy, rehabilitation, automobile safety and safe winter driving.

* * *

RECEIVES AWARD—Emilie Gleason Sargent, executive secretary of the Visiting Nurse Association of Detroit, received the University of Michigan "Outstanding Achievement Award" recently. The Award, first given to a woman since its inception in 1958, recognized Miss Sargent's outstanding achievements in the field of health and nursing education. Miss Sargent also received the 1960 Pearl McIver Public Health Nurse Award of the American Nursing Association.

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ST. MARY'S GRAND ROUNDS—Saint Mary's Hospital of Grand Rapids held a Grand Rounds program December 1, 1960 at the Pantlind Hotel. The participants were John Bamber Hickham, M.D., Indianapolis; John F. McDonald, M.D., Detroit; Carl A. Moyer, M.D., St. Louis; and Harold O. Peterson, M.D., Minneapolis. The general topics were "Biliary Tract Disease" and "Gastrointestinal Bleeding."

* * *

NEW PROFESSOR—David Hywell Davies, M.D., of London, England, has been appointed assistant professor in the department of medicine at Wayne State University College of Medicine. Dr. Davies, whose major research area is cardiology, was on the teaching staff of the National Heart Hospital and Institute of Cardiology in London.

He is a graduate of Oxford, receiving his medical degree in 1952.

* * *

ELECTED—Chosen by his fellow physicians, Josef S. Rozan, M.D., of Lansing, is the new chief of staff at the Edward W. Sparrow Hospital. He succeeds F. Mansel Dunn, M.D. Other new Sparrow staff officers are Philip F. Lange, M.D., vice-chief, and S. P. Fortino, M.D., secretary-treasurer.

* * *

HEADS CORNELL PROJECT—Robert A. Wolf is the new director of the Cornell University Automotive Crash Injury Research program. Mr. Wolf was a member of the technical staff of Cornell Aeronautical Laboratory, Inc., Buffalo, New York. This new arrangement will facilitate closer coordination between the Cornell Automotive Crash Injury Research program and Cornell Aeronautical Laboratory, both of which have been engaged in different phases of automotive safety research for many years. Mr. Wolf holds his Masters Degree in Aeronautical Engineering from the University of Michigan.

MSMS is one of the medical organizations cooperating with Cornell in its studies.

* * *

RETIRES—Ralph G. Sickels, advertising-public relations executive for Parke, Davis & Company, has retired after 40 years' service. He is 68.

As advertising director, he launched the institutional advertising campaign in national magazines in 1928, which is continuing.

In 1957, the American Medical Association awarded Parke-Davis a citation for "the service it has performed to the public and the nation through its continuing series of institutional messages published in national magazines which accurately and dramatically tell the story of medicine and medical progress."

* * *

APPOINTED—Allen W. Byrnes, M.D., formerly with the Veterans Administration hospital at Battle Creek, has been named manager of the VA hospital at Knoxville, Iowa. Dr. Byrnes received his medical degree from Iowa State University and has been with the Veterans Administration since 1940.

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HONORED—Howard P. Doub, M.D., *(left)*, Detroit radiologist, receives a silver tray commemorating 20 years as Editor of the journal *Radiology* from T. J. Wachowski, M.D., Chicago, president of the Radiological Society of North America. The engraving on the tray noted: "To Howard P. Doub, M.D., in appreciation of 20 years loyal service as Editor of *Radiology*."

Dr. Doub is consultant in radiology to Henry Ford Hospital in Detroit, where he had served for many years prior to his recent retirement as director of radiology. He received his medical degree from Johns Hopkins University in Baltimore, Md.

* * *

ON DIABETES PROGRAM—Jerome W. Conn, M.D., Ann Arbor, discussed "A Concept of the Diabetogenic Period in Man with Study of One Parameter" at the Ninth Postgraduate Course on Diabetes and Basic Metabolic Problems at the Louisiana State University of Medicine in January.

* * *

HELPS CANCER SEARCH—A Colostomy Clinic has been established at the Cancer Center, 4811 John R., Detroit, sponsored by the Michigan Cancer Foundation. The Clinic is under the direction of Norman D. Nigro, M.D., Clinical Assistant Professor of Surgery, Wayne State University College of Medicine.

The clinic, established by the cancer foundation with the approval of the Michigan Proctologic Society, is designed to rehabilitate cancer patients having undergone colostomies through professional instruction in proper control and management.

* * *

RESEARCH GRANTS—The University of Michigan ranks fifth nationally in the dollar value of research grants from the National Institute of Health. During fiscal 1960, the U-M received a total of $4,144,910 to support 192 research projects. This figure was topped only by the Uni-

versity of California, Harvard University, New York University, and Johns Hopkins University.

OFFER NEUROLOGY COURSE—The American Academy of Neurology will hold its thirteenth annual meeting at the Sheraton-Cadillac Hotel in Detroit, Michigan, April 24-29.

In order to aid the practicing physicians of the region to keep abreast with the new advances in neurology, a review course in the more common neurologic disorders will be offered on Wednesday, April 26. Credit for attendance at this course will be given by the American Academy of General Practice in Category A, 8 hours. The faculty will consist of some of the foremost neurologists of the country. This course will cover some of the more common neurologic disturbances that the physician meets in his practice.

The subjects to be covered are: The Elicitation and Interpretation of Early Signs of Nervous System Disease; Headache—Diagnosis and Management; Strokes—Natural History and Recent Trends in Treatment; Epilepsy; The Neurology of Aging, including Parkinson's Disease; Neurological Complications of Pregnancy; Common Disorders of Muscle, and The Paraplegic States, including Heredodegenerative Disorders.

Other review courses are being offered from April 24-26. The chairman of each of these courses is an outstanding member in the field of neurology. A brochure describing the courses and application blanks may be obtained from Special Courses, American Academy of Neurology, 4307 East 50th Street, Minneapolis 17, Minnesota.

MEDICAL MEETINGS USA

American College of Surgeons, Sectional Meetings for Surgeons and Graduate Nurses, March 6-9, 1961, Hotels Bellevue-Stratford, Ben Franklin, and Sylvania, Philadelphia, Pa. William E. Adams, M.D., 40 E. Erie St., Chicago 11, Secretary.

American College of Allergists, March 12-17, 1961, Statler Hilton Hotel, Dallas, Texas. Howard G. Rapaport, M.D., 16 E. 79th St., New York City, Secretary.

National Health Council, National Health Forum, "Health and Communication," March 13-16, 1961, Waldorf-Astoria Hotel, New York City. Mr. Philip E. Ryan, 1790 Broadway, New York 19, Executive Director.

American Industrial Health Conference, April 11-13, 1961, Biltmore Hotel, Los Angeles, Calif. Clark D. Bridges, 28 E. Jackson Blvd., Chicago, Managing Director.

Spring Meeting of American Academy of Pediatrics, April 10-12, 1961, Sheraton-Park Hotel, Washington, D. C. For information write E. H. Christopherson, M.D., 1801 Hinman Ave., Evanston, Ill., Executive Director.

Clinical Reviews, Mayo Clinic and Mayo Foundation, April 10-12, 1961, Rochester, Minnesota; for information contact Clinical Reviews Committee, Mayo Clinic, Rochester, Minnesota.

Ohio State Medical Association, April 10-13, 1961, Netherland-Hilton Hotel, Cincinnati, Ohio. Mr. Charles S. Nelson, 79 E. State St., Columbus 15, Executive Secretary.

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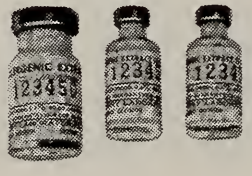
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American Academy of General Practice, April 13-20, 1961, Miami Beach, Fla. Mr. Mac F. Cahal, Volker Blvd. at Brookside, Kansas City 12, Mo., Executive Director.

American College of Obstetricians and Gynecologists, April 21-28, 1961, Americana Hotel, Miami Beach, Fla. Mr. Donald F. Richardson, 79 W. Monroe St., Chicago 3, Ill., Executive Secretary.

Thirty-second Annual Meeting of Aerospace Medical Association, April 24-26, 1961, Chicago. William J. Kennard, M.D., c/o Washington National Airport, Washington, D. C., Secretary-Treasurer.

American Association for Thoracic Surgery, April 24-26, 1961, Sheraton Hotel, Philadelphia, Pa. Hiram T. Langston, M.D., 308 Carondelet Bldg., 7730 Carondelet Ave., St. Louis 5, Secretary.

American Pediatric Society, May 2-3, 1961, Hotel Traymore, Atlantic City. Conrad M. Riley, Denver General Hospital, Denver 4, Secretary.

Student American Medical Association, Congress, May 3-7, 1961, Chicago. Mr. Russell F. Staudacher, 430 N. Michigan Ave., Chicago 11, Executive Director.

American Society of Internal Medicine, May 5-7, 1961, Eden Roc Hotel, Miami Beach, Fla. Mr. G. Tod Bates, 350 Post St., San Francisco 8, Executive Director.

American College of Physicians, May 8-12, 1961, Americana Hotel, Miami Beach, Fla. Edward C. Rosenow, Jr., M.D., 4200 Pine St., Philadelphia 4, Executive Director.

American Psychiatric Association, May 8-12, 1961, Morrison Hotel, Chicago. C. H. Hardin Branch, M.D., 156 Westminster Ave., Salt Lake City 15, Utah, Secretary.

Illinois State Medical Society, May 15-18, 1961, Mr. R. Richards, 360 N. Michigan, Chicago 1, Executive Administrator.

American College of Cardiology, Inc., May 16-20, 1961, Biltmore Hotel. Philip Reichert, M.D., 350 Fifth Ave., Empire State Bldg., New York 1, Executive Director.

American Association of Plastic Surgeons (members and guests), May 17-19, 1961, Commodore Hotel, New York City. Thomas D. Cronin, M.D., 6615 Travis St., Houston 25, Texas, Executive Secretary.

American Orthopaedic Association (members and guests), May 22-25, 1961, The Ahwahnee, Yosemite, Calif. Lee Ramsay Straub, M.D., 535 E. 70th St., New York 21, Secretary.

American Urological Association, Inc., May 22-25, 1961, Biltmore Hotel, Los Angeles. Mr. William P. Didusch, 1120 N. Charles St., Baltimore 1, Executive Secretary.

National Tuberculosis Association, May 22-25, 1961, Netherland-Hilton, Cincinnati. Mr. James G. Stone, 1790 Broadway, New York 19, Executive Secretary.

American Otological Society, Inc., May 26-27, Lake Placid Club, Essex County, N. Y. James A. Moore, M.D., 525 E. 68th St., New York 21, Secretary-Treasurer.

American Gynecological Society, May 29-31, 1961, The Broadmoor, Colorado Springs, Colo. Albert H. Aldridge, M.D., 899 Park Ave., New York 21, President.

American Ophthalmological Society (members only), May, The Homestead, Hot Springs, Va. Joseph A. C. Wadsworth, M.D., 108 E. 68th St., New York 21, Executive Secretary.

Say you saw it in the Journal of the Michigan State Medical Society

IN MEMORIAM

SAUL BARNETT, M.D., sixty-six, Detroit, ear, nose and throat specialist, died December 4, 1960. Doctor Barnett was a graduate of Detroit Medical College and studied at the University of Vienna. He was a past president of Maimonides Medical Society and a member of Temple Israel and Moslem Shrine.

HERBERT F. KILBORN, M.D., eighty-six, an Ithaca physician, died November 23, 1960.

A native of Ontario, Canada, Doctor Kilborn came to the United States in 1902, having graduated with a Master of Surgery degree from Queens University medical school in 1898. He attended Wayne State University College of Medicine, received his M.D. in this country.

In the more than 50 years he was in active practice, Doctor Kilborn took many postgraduate and short courses in medicine. He was an associate Fellow in Postgraduate Medical Education and held an honorary life membership in the Wayne State University College of Medicine.

Doctor Kilborn was a life member of the Ithaca Masonic Blue Lodge, a member of the Royal Arch Masons and the Knights Templar. He was a charter member and past president of the Ithaca Rotary club.

A recipient of many citations, medals and awards from the government, the FBI and veterans groups, Doctor Kilborn was awarded the first Ithaca Chamber of Commerce "Community Service Award" in January, 1960.

JOSEPH O. KOPEL, M.D., seventy, Detroit, physician for 48 years, died, December 7, 1960.

A native of Detroit and a graduate of the Detroit College of Medicine in 1912, he was a member of the Jewish Welfare Federation, the Standard Club and Congregation Shaarey Zedek.

ROBERT L. PHILLIPS, M.D., seventy, a retired Flint surgeon, died December 13, 1960.

Doctor Phillips moved to Florida in 1953, after retirement from his Flint practice.

In September, Doctor Phillips was named a life member of the Genesee County and Michigan State Medical Societies, an honor given to physicians who have reached 70 or who have been practicing 50 or more years.

A graduate of Detroit Medical School, Doctor Phillips was licensed to practice medicine in Michigan in 1914. He served an internship at Providence Hospital, Detroit.

In 1929, he completed postgraduate training in obstetrics

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and gynecology at P.D. and Lying-In-Hospital, New York City.

During World War I, Doctor Phillips was a captain in the Army serving with the 351st Ambulance Company, 88th Division.

WALTER J. WRIGHT, M.D., eighty-five, an Ypsilanti physician from 1902 until his retirement in 1948, died November 19, 1960.

Doctor Wright was born in Mason, was graduated from the University of Michigan Medical School in 1898 and later did graduate work at the Johns Hopkins University and at Harvard University.

He was a member of the Methodist Church, a life member of Phoenix Lodge F & AM No. 13, member of the Commandery, Order of Eastern Star, medical affiliations and served as a staff member of the Beyer Memorial Hospital until his retirement and since then had served as an honorary member.

J. PAUL YEGGE, M.D., fifty-five, Muskegon physician, died December 8, 1960.

A native of Boone, Iowa, Doctor Yegge received his M.D. degree from the University of Iowa. He came to Michigan shortly after and practiced for a number of years at Kent City before going to Muskegon to establish a practice three years ago. He was interested in sports and served as team physician for Muskegon Catholic Central High School.

In addition to his professional affiliations, he was a member of Muskegon Elks Lodge, Our Lady of Grace Catholic Church and the Holy Name Society.

Michigan Blue Cross Tops $1 Billion Mark

Michigan Blue Cross has hit and passed *one billion dollars* in benefit payments for hospital care for Blue Cross members.

Wm. S. McNary, executive vice president, said $1,000,000,000 in benefits was reached and topped in a check to Sparrow Hospital in Lansing. The check covered services to Blue Cross patients billed by the hospital in November.

Mr. McNary said that payment of more than one billion dollars in benefits for hospital care for Blue Cross members in less than twenty-two years "is an historic and impressive milestone in voluntary prepayment in Michigan."

Nursing Scholarship At Wayne University

Applications for six four-year scholarships for Wayne State University's College of Nursing are due on or before March 1 for the fall semester.

Five Helen Newberry Joy Scholarships worth $1,234 each are offered to residents of Metropolitan Detroit. The College of Nursing Alumni Association Scholarship is worth $1,150 and is open to any qualified applicant.

Scholarship applications are available at most high schools and through the College of Nursing, Cohn Building, 5557 Cass, Detroit 2.

Say you saw it in the Journal of the Michigan State Medical Society

COMMUNICATIONS

Michigan State Medical Society

Gentlemen:

At the annual business meeting of the Michigan Probation, Prison and Parole Association held September 29, 1960, the following resolution was unanimously adopted and presented for your consideration and support.

RESOLVED: That the Michigan Medical Association be advised by the Michigan Probation, Prison and Parole Association that the Association has recognized the value of the drug Naline, in the detection of addicts, and that the use of this drug be included as a part of Parole or Probation supervision in cases involving drug addicts.

Respectfully submitted,
GORDON FULLER, *President*
Michigan Probation, Prison and Parole Association

Jackson, Michigan
December 9, 1960

Mr. William J. Burns
Executive Director
Michigan State Medical Society

Dear Mr. Burns:

The Dependents' Medical Care Program began its fifth year of operation on 7 December 1960.

We in the Office for Dependents' Medical Care are extremely proud of the manner in which the Program has been accepted and supported by civilian physicians and hospitals. We are cognizant of the fact that such acceptance would not have been possible but for the highly efficient and conscientious manner in which the various medical societies and fiscal administrators have administered the Program. For this, we are deeply appreciative.

Sincerely,
FLOYD L. WERGELAND
Brigadier General, MC
Executive Director, Office for Dependents' Medical Care

To Give Hickey Lecture

C. Allen Good, M.D., chief of the department of radiology, Mayo Clinic, will deliver the Hickey Memorial Lecture under the combined auspices of the Detroit Roentgen Ray and Radium Society, Wayne County Medical Society and Wayne State University College of Medicine on March 2, at 8 p.m. in the auditorium of the Wayne County Medical Society headquarters.

A subscription dinner will precede the lecture at 7 p.m.

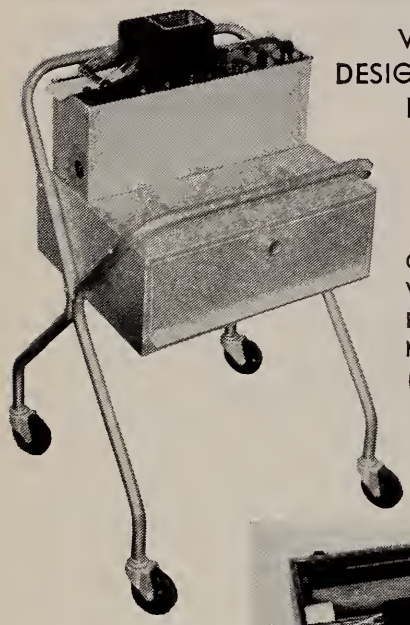
Dr. Good will speak on "Certain Vascular Abnormalities of the Lungs."



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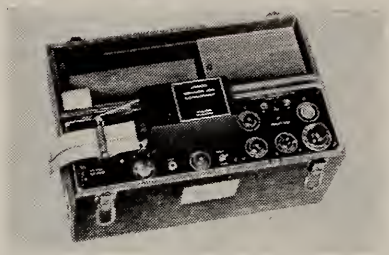
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The Doctor's Library

Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

INFECTIOUS DISEASES OF CHILDREN. By Saul Krugman, M.D., Professor and Chairman, Department of Pediatrics, New York University School of Medicine, New York, N. Y.; Director, Pediatric Service, Bellevue Hospital Center, New York, N. Y.; Director, Pediatric Service, University Hospital, New York, N. Y., and Robert Ward, M.D., Professor and Head, Department of Pediatrics, University of Southern California School of Medicine, Los Angeles, Calif.; Physician-in-Chief, Children's Hospital, Los Angeles, Calif. Second edition. With 55 Illustrations and 7 Color Plates. St. Louis: The C. V. Mosby Company, 1960. Price, $13.00.

The book makes the common cold less of an enigma. It resolves colds into an entity with an etiology, course, and treatment. The contagious diseases are carefully described. There are new chapters on acute respiratory infections and enterovirus diseases. Rabies and toxoplasmosis have been added. There is much recent material on herpetic infections, poliomyelitis vaccine, diphtheria, rubella, meningitis and staphylococcus infections. Infectious diseases in children constitute the larger part of the pediatrician's work.

The book is a new and helpful aid to practitioners dealing with infections in children.

R.S.S.

CONTRIBUTIONS TO OBSTETRICS AND GYNAECOLOGY. By B. N. Shirodkar, M.D. (Bombay), F.R.C.S Emeritus Professor of Obstetrics and Gynaecology, Grant Medical College, Bombay. Edinburgh and London: E. & S. Livingstone, Ltd., 1960. Price, $8.50.

This is an excellent advance in the field of gynecological surgery. The many actual photographs of the various surgical procedures are self explanatory. Definitely, useful contributions in this field are the chapters on prolapse of the uterus, tuboplasty, artificial vagina, and the operative procedure for habitual abortion. Of special interest to all physicians who are doing surgery is the use of mersilene tape and thread. The final chapter is a summary of various papers on gynecology and obstetrics written by the author. One of the most interesting chapters is on cesarean section with use of the Morrison forceps. The diagrams of external version give a very clear illustration of the procedure.

This book is of the greatest importance to all men doing obstetrics and gynecology and to the general surgeon.

J.R.P.

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March, 1961

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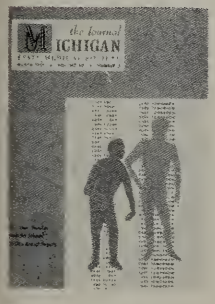
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THE COVER

This number of THE JOURNAL is dedicated to the care of and the hope for arthritic patients. In addition to the excellent scientific articles, your attention is directed to the President's Page.

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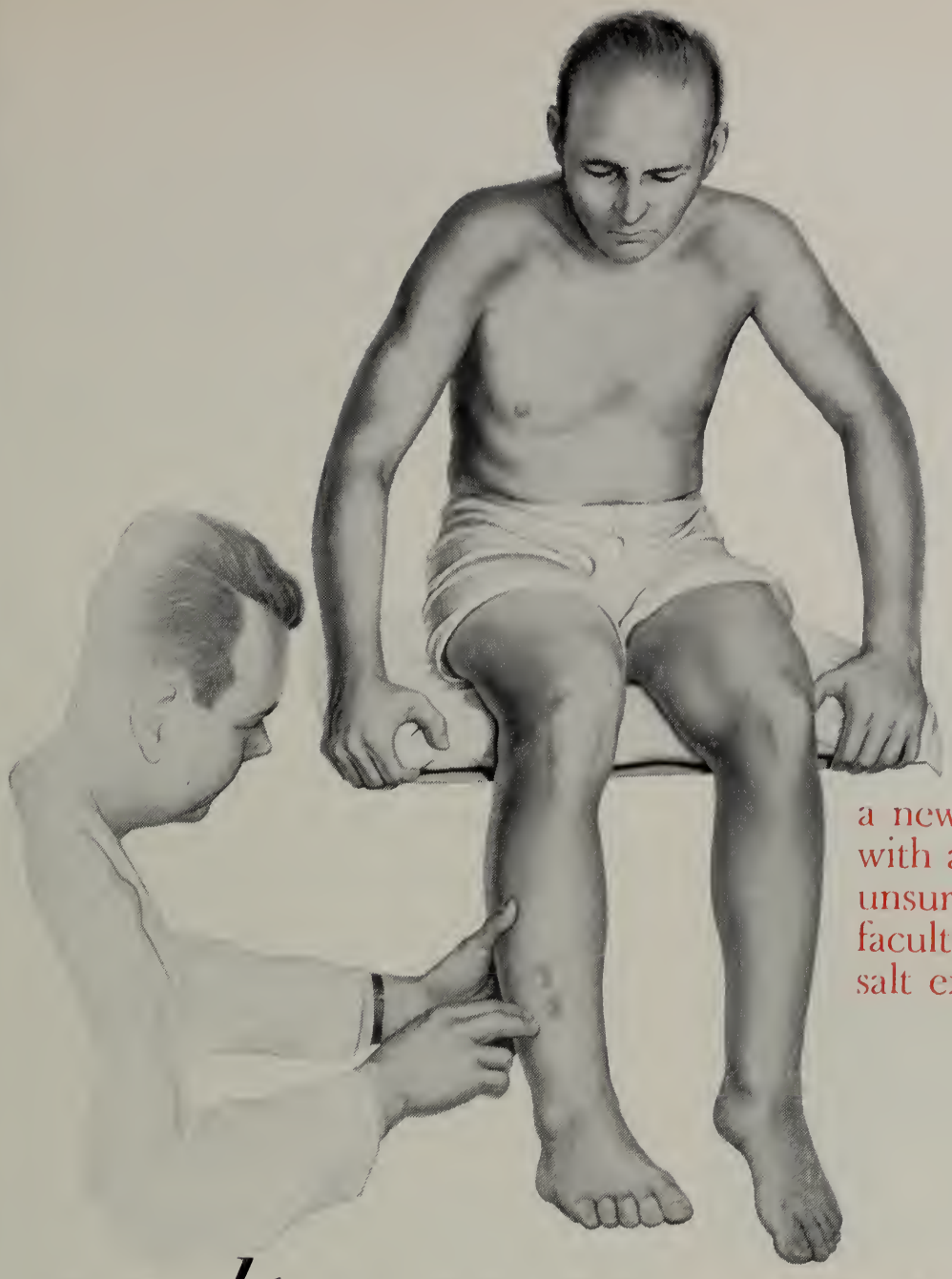
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President's Page

SUCCESSFUL CARE OF ARTHRITIS



It is not often that your President chooses to discuss a clinical subject, even briefly, since these matters are so much better handled by others. I should like this time, however, to call your very special attention to the subject of this number of THE JOURNAL which is dedicated to "Arthritis."

It would be quite ridiculous to suggest that this condition is the "No. 1 Enemy" defying medical practice to solve. There are so many. But I am sure that each of us has been aware, in one way or another, of the challenge to our best efforts which this crippling "disease" presents.

I am personally mindful of those patients I see, who are rigidly restrained from living even the semblance of a normal life due to this affliction. Fortunate are they indeed if they have families and friends to minister to their needs. Even so, their lives are circumscribed to the point of utter helplessness in part or completely.

There seems no other situation which requires such a degree of patience on the part of the physician. Patience which offers hope, but not too much hope. Patience which offers friendship, as well as medical know-how. Patience which is able to delineate for the victim those ideas which may help from those which are only a waste of his time, energy, and money.

I can recall driving several miles, as a young physician, to bring diathermy to a bed-ridden arthritic patient. In the light of present knowledge, it was a wasted effort, but then it was the thing to do. The advent of the steroids seemed to offer a panacea, but now we know the limitations as well as the advantages of this form of treatment. How often are we faced with the problem of gently telling a sufferer—"No, I do not believe that sitting in an underground cave where radio-activity is supposed to abound will cure your affliction," or some similar miraculous notion.

Above all, I suggest that the role of the physician in caring for this "disease" is one of courageous effort and friendly assistance salted with a dash of healthy skepticism. At present, such an approach offers the best chance for successful care.





Dedication Set June 4

Preliminary plans have been started for the dedication program of the new MSMS Headquarters Building Sunday, June 4, at 3:00 p.m.

All members of MSMS and their ladies are invited to attend the event, with special invitations extended to the members of the MSMS House of Delegates and The MSMS Council.

"Every member can be proud of the new headquarters as the functional center for health activities in Michigan," points out Kenneth H. Johnson, M.D., MSMS President.

* * *

PLANS FOR THE DEDICATION were approved at the annual meeting of The Council and now are being implemented by the Big Look Committee, The Council and MSMS officers.

While the June 4 official dedication program for MSMS members will be the major event, several other open-house programs are being arranged for leaders in government, the health field, community affairs, and for other groups.

Many presidents, secretaries and leaders of component medical societies toured the Headquarters building during the annual County Secretaries-Public Relations Seminar. Since then, workmen have completed the interior work.

The MSMS staff expects to move its operation to the new Headquarters in April.

* * *

ALL MEMBERS ARE cordially invited to visit the new Headquarters anytime after the move has been completed so they may inspect the functional design of the building and the efficient arrangement of conference rooms, offices, production room and other facilities.



Annual County Secretaries Public Relations Seminar

The Annual County Secretaries' Public Relations Seminar which was held in East Lansing, January 23 and 29, 1961, had a total registration of 138. Those present included:

County Secretaries.—H. E. Schneiter, M.D. (Allegan), Harold Kessler, M.D. (Alpena-Alcona-Presque Isle), D. H. Castleman, M.D. (Barry), H. T. Knobloch, M.D. (Bay-Arenac-Iosco), W. J. Kenfield, M.D. (Berrien), G. D. Maniaci, M.D. (Delta-Schoolcraft), A. F. Dundon, M.D. (Grand Traverse-Leelanau-Benzie), J. B. Rowe, M.D. (Genesee), B. H. Smookler, M.D. (Ingham), H. W. Porter, M.D. (Jackson), R. H. Hume, M.D. (Kalamazoo), Kornelius Van Goor, M.D. (Kent), F. A. Locke, M.D. (Lenawee), R. M. Duffy, M.D. (Livingston), J. M. Carter, M.D. (Marquette-Alger), G. H. Hopson, M.D. (Menominee), R. A. Frary, M.D. (Monroe), H. C. Tellman, M.D. (Muskegon), T. R. Kirk, M.D. (Northern Michigan), E. J. Westfall, M.D. (Oakland), Michael Raftery, M.D. (St. Clair), D. E. Bradley, M.D. (St. Joseph), A. E. Parks, M.D. (Van Buren), H. A. Howes, M.D. (Wayne).

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Participants on Program.—Senator Frank D. Beadle (St. Clair), Hugh W. Brenneman (Lansing), Lester P. Dodd, LL.B. (Detroit), Otto K. Engelke, M.D. (Ann Arbor), H. F. Falls, M.D. (Ann Arbor), R. A. Frary, M.D. (Monroe), H. A. Howes, M.D. (Detroit), K. H. Johnson, M.D. (Lansing), J. J. Lightbody, M.D. (Detroit), W. J. Maxey (Lansing), Professor Walter McNerney (Ann Arbor), H. J. Meier, M.D. (Coldwater), J. A. Read, M.D. (Birmingham), J. B. Rowe, M.D. (Flint), F. C. Swartz, M.D. (Lansing), R. Wallace Teed, M.D. (Ann Arbor), H. C. Tellman, M.D. (Muskegon), D. B. Varner, Ph.D. (Rochester, Michigan), D. Bruce Wiley, M.D. (Utica), F. M. Woolsey, Jr. (Albany, N. Y.), Jean Worth (Escanaba).

Guests.—John A. Doherty, M.D. (East Lansing), Duane Drake (Detroit), Juanita Ferman (Jackson), Wm. C. Fritz (Lansing), Joseph D. Miller (Chicago, Ill.), Dr. and Mrs. R. L. Novy (Detroit), R. V. Taylor, M.D. (Jackson), A. H. Veldhuis, M.D. (Mt. Pleasant), Marguerite M. Vergosen (Detroit), David Wilson (Detroit).

MICHIGAN MEDICAL MEETINGS AND CLINIC DAYS

April 6	Ingham County Clinic Day	Jack Tar Hotel, Lansing
April 26-29	American College Health Association	Detroit
April 27-29	American Academy of Neurology	Sheraton-Cadillac Hotel, Detroit
May 3	Wayne State University Alumni Clinic Day and Reunion	Fort Shelby Hotel, Detroit
May 23-25	Michigan Health Council State Conference	Ballengar Field House, Flint Community College, Flint
June 4	Dedication of New MSMS Headquarters	East Lansing
June 16-17	Upper Peninsula Medical Society	Menominee
June 19-21	University of Michigan Conference on Aging	Ann Arbor
July 27-28	Coller-Penberthy Clinic	Park Place Hotel, Traverse City

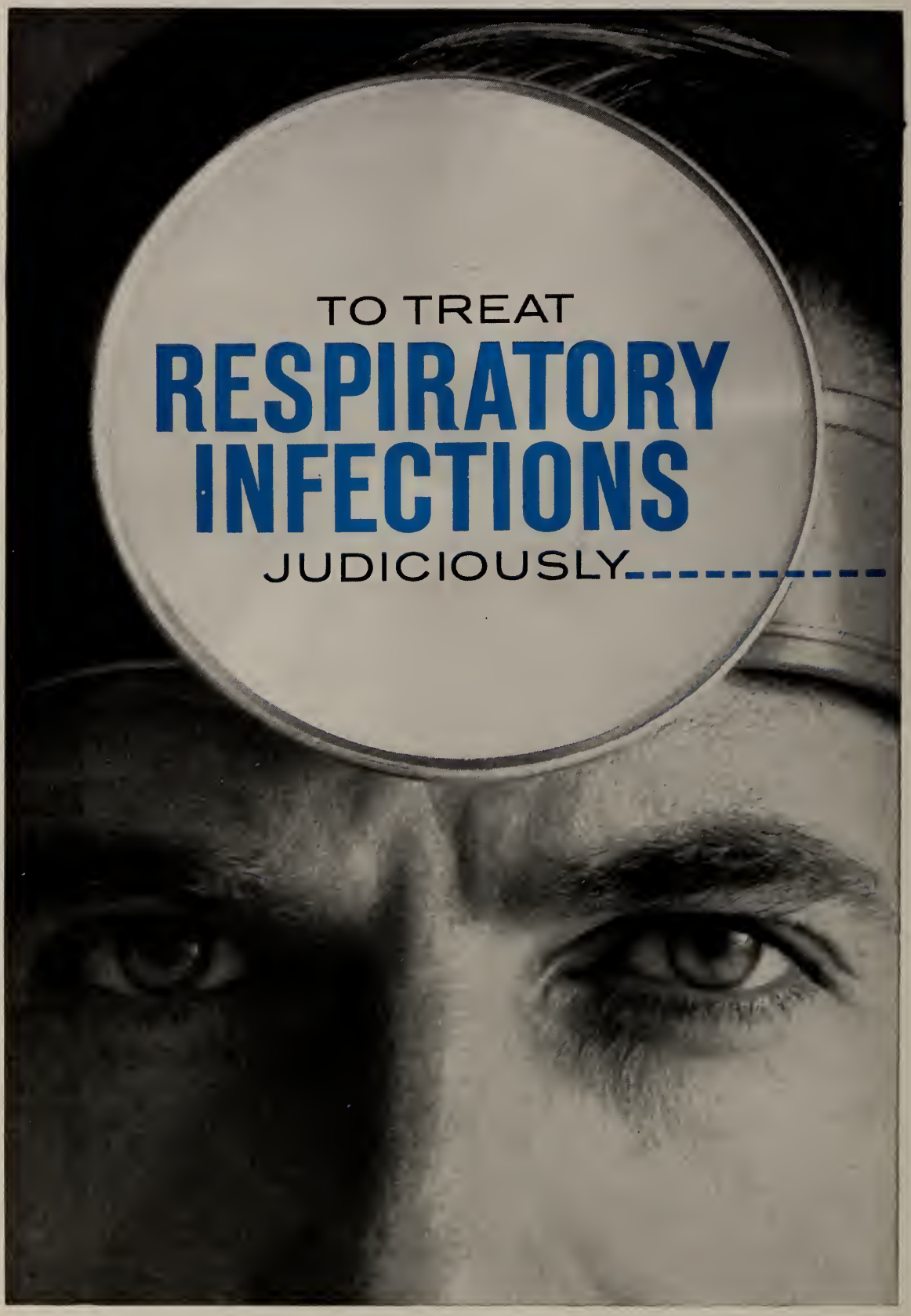
RECORD OF ATTENDANCE AT MSMS COUNTY SECRETARIES-PUBLIC RELATIONS SEMINAR

X Present
O Absent
N None

January 28-29, 1961

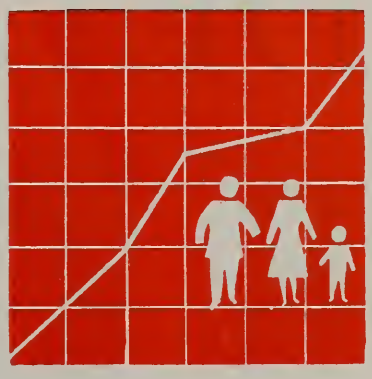
County or District Medical Society	*Pres.*	*Pres. Elect*	*Secy.*	*County P.R. Chairmen*	*Editor*	*MSMS Councilor*	*MSMS P.R. Committee*	*Exec. Secy.*
Allegan	X	O	X	O	X	N	N	N
Alpena-Alcona-Presque Isle	O	O	X	O	N	N	O	N
Barry	X	N	X	O	N	N	O	N
Bay-Arenac-Iosco	X	O	X	X	O	X	X	N
Berrien	O	O	X	O	O	N	N	N
Branch	O	N	O	N	O	X	N	N
Calhoun	O	O	O	O	O	N	O	N
Cass	O	N	O	N	N	N	N	N
Chippewa-Mackinac	O	O	O	N	N	N	O	N
Clinton	O	O	O	O	N	N	O	N
Delta-Schoolcraft	O	O	X	N	N	X	O	N
Dickinson-Iron	O	X	X	O	N	N	N	N
Eaton	O	O	O	N	N	N	N	N
Genesee	X	X	X	O	X	X	XXX	X
Gogebic	O	O	O	N	N	N	N	N
Grand Traverse-Leelanau-Benzie	O	O	X	X	O	N	N	N
Gratiot-Isabella-Clare	O	N	O	N	N	X	X	N
Hillsdale	O	O	O	N	N	N	N	N
Houghton-Baraga-Keweenaw	O	O	O	O	N	O	O	N
Huron	O	O	O	O	N	N	N	N
Ingham	X	X	X	X	X	XX	X	X
Ionia-Montcalm	X	X	O	O	N	N	N	N
Jackson	X	O	X	X	N	N	N	N
Kalamazoo	X	X	X	X	O	X	X	X
Kent	X	X	X	O	O	X	OOO	X
Lapeer	O	N	O	O	N	N	N	N
Lenawee	O	O	X	O	O	N	N	N
Livingston	O	O	X	X	N	N	O	N
Luce	O	O	O	O	N	N	N	N
Macomb	X	O	O	O	N	X	X	N
Manistee	O	O	O	O	O	N	N	N
Marquette-Alger	O	X	X	O	N	N	X	N
Mason	O	N	O	N	N	N	N	N
Mecosta-Osceola	O	O	O	X	N	N	N	N
Menominee	O	O	X	X	N	N	N	N
Midland	O	O	O	O	N	N	N	N
Monroe	O	X	X	X	N	N	X	N
Muskegon	X	X	X	X	O	X	O	X
Newaygo	O	O	O	O	N	N	N	N
North Central	O	O	O	N	N	N	N	N
Northern Michigan	O	O	X	N	N	N	X	N
Oakland	O	X	X	X	O	O	O	X
Oceana	O	N	O	N	N	N	N	N
Ontonagon	O	O	O	O	O	N	O	N
Ottawa	O	O	O	N	N	N	N	N
Saginaw	O	O	O	O	O	O	O	O
St. Clair	X	X	X	X	O	X	N	N
St. Joseph	O	O	X	X	N	N	X	N
Sanilac	O	O	O	O	N	N	N	N
Shiawasee	O	O	O	O	N	N	X	N
Tuscola	X	O	O	N	N	O	N	N
Van Buren	O	O	X	N	N	N	N	N
Washtenaw	X	X	O	X	O	XX	XX	O
Wayne	O	X	X	X	O	XXXX	XX	X
Wexford-Missaukee	O	O	O	N	N	X	N	N

Others present at the Seminar were: Woman's Auxiliary representatives, 3; Michigan State Medical Assistants Society representatives, 4; Michigan Medical Service representatives, 3; Michigan Hospital Service representatives, 2; Program Participants, 21; guests, 11.



Say you saw it in the Journal of the Michigan State Medical Society

Real Cost of Medical Care Lower than 20 Years Ago



The real cost of medical care, in terms of hours of work to purchase it, is less today than it was 20 years ago. This is the conclusion of the American Medical Association's Economic Research Department, based on data from the Bureau of Labor Statistics.

"The time that a factory employee worked in 1959 to purchase a given 'market basket' of medical care was only 61 per cent of the amount of time required in 1939, a decrease of 39 per cent," the AMA reported.

To pay for physicians' services required only 55 per cent as much working time in 1959 as in 1939. In 1959, a worker could earn the money to pay for a constant quantity of surgeons' services in less than half the time required in 1939, the AMA said.

Only one part of medical care—hospital rates—required more working time to cover the increased cost. The factory worker in 1959 put in 122 per cent of the time worked in 1939, in order to purchase the same quantity of hospital services.

The AMA pointed out, however, that qualitative changes in medical practices have resulted in shortened periods of hospitalization. Two examples are cited—20 years ago the average length of stay for a hemorrhoidectomy was 19.6 days, whereas today it is 7.6 days, and the average length of stay for an appendectomy was 13.5 days, whereas, today it is only 6.7 days.

"Included in this decrease of real cost of medical care is the higher quality of today's service," the AMA said. "Research and progress have produced drugs, technological instruments and improved methods in the management of disease which were non-existent 20 years ago."

* * *

AMA Washington Statement About Kennedy Health Plan

"President Kennedy's sweeping health program, tied to an increase in social security taxes to finance medical care for elderly persons, faces strong opposition in Congress.

"The consensus of Capitol Hill observers was that it stood a 50-50 chance of getting Congressional approval but not before it had been cut down. There were some who doubted that the Administration's program for medical care of the aged would be acted upon, at least by both houses of Congress before next year.

"Even some Democratic Congressmen with the liberal label were taken aback by the scope of Kennedy's health program."

Each of the babies pictured on this page was borne by a mother with a *documented* previous history of true habitual abortion, who was treated with DELALUTIN during the pregnancy leading to this birth

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Evaluation of Two Electron Microscope Techniques, The Artefacts Involved, and Their Bearing on The Interpretation of Published Work

M. K. Keech, M.D.
Detroit, Michigan



A TIME-HONOURED method for preparing biological specimens for examination in the electron microscope (EM) is disintegration in a tissue grinder until the particles of the suspension are small enough to enable photographs to be taken of their fine structure. No critical analysis or assessment of the artefacts involved has been published, and no comparison with other methods, employing the same material, has been made. This study was planned to remedy this omission and to re-examine published work in the light of the results. In the course of this investigation, new observations were recorded on the relative *stability* of collagen fibrils re-precipitated by different methods as compared with fresh dermal collagen.

Materials and Methods

Table 1

Re-precipitated Collagen.—The substrates used were those prepared by Wood[25] and whose EM morphology has been described elsewhere.[17] The purpose of present study was the comparison of the undisturbed, replicated reaction mixture and samples ground for varying lengths of time. Briefly, salt-extracted calf dermis was solubilised in acetic acid and the collagen then re-precipitated by the addition of phosphate buffer pH 7.0 either alone (controls), or in the presence of ribonucleic acid (RNA), desoxyribosenucleic acid (DNA), purified chondroitin sulphate (CSA) b and c (supplied by K. Meyer) or heparin. The final reaction mixtures had a collagen concentration of 0.05 per cent, a phosphate concentration of 0.04 M, ionic strength 0.2 and a concentration of special substances (DNA, et cetera) of 0.005 per cent except the heparin which was 0.0005 per cent. The preparations were examined after twenty-four hours at the various temperatures detailed in Table I.

1. *Replicas:*—This method has been described in detail by Wood and the author.[26] Portions of the metal-shadowed replica of the surface of the undisturbed reaction mixture were picked up on grids and examined in the EM.

2. *Ground Samples:*—Samples were taken after grinding 3, 12, or 20 times as indicated in Table I, placed on collodion-covered 200-mesh copper grids, allowed to dry, washed with distilled water, shadowed with chromium, and examined in a Siemen's electron microscope, type UM 60 C.

Dr. Keech is Associate Professor of Medicine in charge of Section of Rheumatology, College of Medicine, Wayne State University. This work was performed by the author in the Department of Medicine, University of Leeds, England, as an Empire Rheumatism Council Research Fellow.

TABLE I. THE EFFECTS OF DIFFERENT METHODS OF PREPARATION ON VARIOUS COLLAGEN SUBSTRATES

Materials and Method			
Untreated PM Dermis	Ground 3 x	Ground 20 x	
9 years	Normal child dermis (see text). Very scanty small DB. Average "elastin" count= 10/square.	Well preserved collagen fibrils. Slight increase in DB and AM. Average "elastin" count= 7.8/square.	
63 years	Normal adult dermis (see text). Very scanty small DB. Average "elastin" count= 3.7/square.	Well preserved collagen fibrils. Slight increase in DB and AM. Average "elastin" count= 4/square.	
Re-precipitated Collagen	Replica	Ground	
Control 24 hours at 20-23°C.	Dense network of collagen (Grade 3). No DB, AM or "elastin."	60% AM 25% DB 1% "elastin" 5% degenerate collagen.	
RNA 24 hours at 20-23°C.	Dense network of collagen (Grade 1). No DB, AM or "elastin."	40% AM 20% DB 1% "elastin" 15-20% collagen.	
DNA 24 hours at 20-23°C.	Abnormal, wide collagen fibres and tactoids. No DB, AM or "elastin."	20% AM 60% DB 5% "elastin" 1-2% degenerate collagen (no tactoids).	
Re-precipitated Collagen	Replica	Ground 3 x	Ground 12 x
Control 24 hours at 23-25°C.	Dense network of collagen (Grade 2). No DB, AM or "elastin."	10% normal and degenerate collagen. Clumps of AM mixed with the collagen. Hardly any DB. Average "elastin" count=6/square.	Unchanged except for slight increase in DB. Average "elastin" count= 5/square.
CSA b 24 hours at 23-25°C.	Very dense network of collagen (Grade 3). No DB, AM or "elastin."	10% normal and degenerate collagen. Clumps of AM mixed with the collagen. Scanty DB. Average "elastin" count= 5/square.	Unchanged except for moderate increase in DB. Average "elastin" count= 7.5/square.
CSA c 24 hours at 23-25°C.	Very dense network of collagen (Grade 3). No DB, AM or "elastin."	10% normal and degenerate collagen. Clumps of AM mixed with the collagen. Scanty DB. Average "elastin" count= 6/square.	Unchanged except for slight increase in DB. Average "elastin" count= 6/square.
Heparin 24 hours at 23-25°C.	Dense network of collagen (Grade 1). No DB, AM or "elastin."	Degenerate collagen. Clumps of AM. Very scanty DB. Average "elastin" count= 4/square.	Unchanged except for marked increase in DB. Average "elastin" count= 5/square.
Re-precipitated Collagen	Replica	Ground 3 x	Ground 20 x
Control 24 hours at 21°C.	Dense network of collagen (Grade 1). No DB, AM or "elastin."	10% normal and degenerate collagen. Clumps of AM mixed with the collagen. Hardly any DB. Average "elastin" count=6/square.	Unchanged except for moderate increase in DB. Average "elastin" count= 8/square.
Control 24 hours at 37°C.	Dense network of collagen (Grade 3). No DB, AM or "elastin."	10% normal collagen. Clumps of AM mixed with the collagen. Hardly any DB. Average "elastin" count= 5/square.	Unchanged except for moderate increase in DB. Average "elastin" count= 7/square.

All fibres exhibited 640 A° cross-banding. For collagen grading see Terminology.
Re-precipitated collagen: Salt-extracted solubilized calf dermis re-precipitated by the addition of phosphate buffer pH 7.0 either alone (controls), or in the presence of ribonucleic acid (RNA), desoxyribosenucleic acid (DNA), purified chondroitin sulphate (CSA) b and c (supplied by K. Meyer) or heparin. The final reaction mixtures had a collagen concentration of 0.05%, a phosphate concentration of 0.04 M. ionic strength 0.2 and a concentration of special substances of 0.005% except the heparin, which was 0.0005%.
All the ground specimens had been diluted with water. The percentages are approximate values assessed by careful examination on the EM screen. Over 1,000 microscopic fields were scrutinized from each specimen and the "elastin" counted in exactly 500 fields (20 squares) the average per square being recorded.
DB=dense bits; AM=amorphous material; PM=postmortem.

Counts of the elastin-like structures ("elastin" in Table I) were made by carefully scanning exactly 500 microscopic fields (20 grid-squares) from two different grids, the average number per square being recorded. The high-power eye-piece was frequently used to establish the identity of the many small pieces seen. Over one thousand microscopic fields were scrutinised from each specimen.

Fresh Dermis.—The unfixed dermis from upper abdominal postmortem skin from two cases, aged nine and sixty-three years, was carefully dissected from the epidermis and subcutaneous tissue, and ground in a glass tissue grinder. Samples were taken after grinding three and twenty times and prepared as described above.

Preparations of *unground* starting material were attempted by teasing the fresh dermis with needles, but satisfactory samples fine enough for electron microscope examination could not be obtained without slight grinding.

TABLE II. ANALYSIS OF COLLAGEN FIBRIL WIDTH AFTER DIFFERENT METHODS OF PREPARATION

Substrate	Experiment	Fibril Width (A°)						Collagen Grading
		<1,000	1,000	1,200	1,400	2,000	3,000	
Untreated PM Dermis 9 years	Ground 3 x	occ.	+++	++	+	−	−	3
	Ground 20 x	occ.	+++	++	−	−	−	
63 years	Ground 3 x	−	+++	++	++	−	−	3
	Ground 20 x	−	+++	++	++	−	−	
Re-precipated Collagen Control	Replica	−	+	+	+	+	−	3
	Ground	occ.	++	+	+	−	−	
RNA	Replica	−	+	+	+	++	+	1
	Ground	−	+	+	++	+++	+	
DNA	Replica	Abnormal compound fibres						−
	Ground	Scanty and difficult to measure						
Re-precipitated Collagen Control	Replica	−	−	−	occ.	++	++	1
	Ground 3 x	−	occ.	occ.	occ.	+++	+	
	Ground 12 x	−	occ.	occ.	occ.	+++	+	
CSA b	Replica	+	++	+	+	−	−	3
	Ground 3 x	occ.	++	+	+	−	−	
	Ground 12 x	occ.	++	+	+	−	−	
CSA c	Replica	+	++	+	+	−	−	3
	Ground 3 x	occ.	++	+	+	−	−	
	Ground 12 x	occ.	++	+	+	−	−	
Heparin 0.0005%	Replica	−	+	+	+	++	+	1
	Ground 3 x	Too degenerate to measure						
	Ground 12 x	Too degenerate to measure						
Re-precipitated Collagen Control (21° C.)	Replica	−	−	−	occ.	+++	++	1
	Ground 3 x	occ.	occ.	occ.	occ.	+++	+	
	Ground 20 x	−	occ.	occ.	occ.	+++	+	
Control (37° C.)	Replica	occ.	+++	+	+	−	−	3
	Ground 3 x	occ.	+++	occ.	occ.	−	−	
	Ground 20 x	occ.	+++	occ.	occ.	−	−	

These data were obtained by analyzing 293 photographic plates with a scaled Leitz eye-peice. Normal (dermal) fibril width is 1,000-1,400 A°. All fibres exhibited 640 A° cross-banding. For collagen grading see Terminology.
PM=postmortem; occ.=occasional; RNA=ribonucleic acid; DNA=desoxyribosenucleic acid; CSA=chondroitin sulphate (purified fractions supplied by K. Meyer).
All the fibrils were long except those precipitated in the presence of heparin and DNA.

Terminology

Collagen Grading.—In normal skin, the fibrils are mainly 1,000-1,400 A° in width, rigid and of indefinite length. Narrow fibrils and visualisation of the (tapered) fibril ends characterise young skin or actively growing tissue.[1-3] The presence of acute bends is evidence of flaccidity of the fibrils as the suspension settles on the grid during drying. Because all the replicated precipitates described in the present paper consisted of collagen only (with hardly any debris and no elastin-like structures, amorphous material or buffer salts), these characteristics at each time-interval could be easily established. Although the deposits were re-precipitated (dermal) collagen and not fresh tissue, the following morphological separation into grades proved valuable.

Grade 1:—Apparently undivided fibrils 2,000-4,000 A° in width, occurring singly or in bundles.
A few 1,000-1,400 A° fibrils.
Frequent acute fibril bends and tapered ends.

Grade 2:—Some 2,000-4,000 A° fibrils but mainly fibrils 1,000-1,400 A° wide, occurring singly or in bundles.
A few tapered ends.

Grade 3:—Long, rigid fibrils 1,000-1,400 A° wide occurring singly or in bundles.
Resembles unfixed, normal, adult dermis.

It should be made quite clear that the above grading is valid for comparative purposes within a particular set of experiments using the *same* collagen extract but, although the principle still holds good, the actual appearance in each grade might differ slightly if another solution of collagen were employed.

Measurement of Fibril Width.—In conformity with present-day terminology, "fibril" denotes an apparently single structure at the magnification used. Fibril width was measured on the EM plates with a scaled Leitz eye-piece (magnification x 8). Only single fibrils were measured, aggregates of fibrils being disregarded. It is assumed that the former provide a representative sample of all the fibrils. Thus, Table II can be compared with the fibril widths reported for fresh tissue by the following authors: Schwarz,[22] Banfield,[3] Burton and Reed,[5] Tunbridge and his associates,[23] Gross and Schmitt,[11] Gross[7,8] and the author.[16]

Results

Tables I and II

The fibres present in all the experiments exhibited 640 A° cross-banding.

Untreated Postmortem Dermis (Plate I, Figs. 1-4).—The unfixed, postmortem derma shows the usual age differences previously described.[16-18] A small quantity of elastin-like material is evenly distributed over all the grids examined and there is no change in the "elastin" counts even when the grinding is increased seven-fold. Also the collagen fibrils remain well preserved. As noted above, it proved impossible to obtain satisfactory *unground* starting materials fine enough for EM examination.

Re-precipitated Collagen (Plate I-V, Figs. 5-27).—The re-precipitated collagen results are summarised in Tables I and II which bring out the following points:

1. The undisturbed, replicated precipitate presents a totally different picture from the ground specimens. The former consists almost entirely of striated collagen, the fibrils varying in width and length according to the experimental conditions (Table II). No dense bits, amorphous material, or "elastin" are seen in any sample—although scanty debris is present. On the other hand, after grinding, the collagen is decreased in amount (see Discussion) being mixed with amorphous material and dense bits. In addition, a small quantity of typical "elastin" is very evenly distributed over all the grids, the counts per square being of the same order as the postmortem dermis. The majority are small pieces of "skin-type elastin"[19] and the high-power eye-piece was frequently employed to ensure their identity.

2. Careful counts do not reveal any significant increase of "elastin" after the longer grinding (four-fold or seven-fold) although, in some specimens, there is an average increase of one piece per square (25 microscopic fields).

3. Grinding definitely breaks down the wide collagen bundles seen in the replicas to smaller bundles or single fibrils, but the basic fibril width appertaining to each experiment remains *unaffected*. This was ascertained by measurement of all undegenerate, in-focus fibrils on 293 photographic plates, as shown in Table II. The plus-minus method of recording gives a general picture of the numbers observed for any given width, but does not necessarily reflect the occasional fibril which may occur outside the extremes of the range encountered.

4. Scanty, dense square-ended fibres (as described by Reed and the author[18]) are present in the postmortem dermis but are absent from all the ground samples of re-precipitated collagen.

5. The influence of the special substances on the (replicated) morphology of the fibrous precipitate has been described in detail elsewhere.[17] For the purpose of the present paper, two major effects are noted, each having a bearing on the other: fibril width and the capacity of the fibrils to withstand grinding. Table II clearly demonstrates that, although the fibril width varies with the experimental conditions, it remains *unaffected* by grinding. Collagen re-precipitated in the presence of CSA (Plate III, Figs. 14-19) is long, rigid and of normal (dermal) width (*Grade 3*). DNA (Plate II, Figs. 9 and 10) and heparin (Plate IV, Figs. 20 and 21) produce short, abnormal, wide structures which are rendered so degenerate by the process of grinding that their width cannot be measured. Collagen re-precipitated by the addition of phosphate buffer alone, that is, the control experiments (Plate II, Figs. 11-13), consists of wider fibrils than either CSA or the untreated postmortem dermis (Plate I, Figs. 1-4).

6. Increase in temperature produces a similar effect to CSA. Control collagen re-precipitated at 21° C. consists mainly of fibrils 2,000-4,000 A° wide, and a proportion of these are rendered degenerate by grinding (Plate IV, Figs. 22-24). In contrast, the precipitate formed at 37° C. is composed of long, rigid fibrils of normal (dermal) width that remain well-preserved even after grinding twenty times (Plate V, Figs. 25-27).

Discussion

The results reported in this paper may be considered from several aspects (1) comparison of replicated and ground EM specimens, (2) the stability of the collagen fibril, (3) recognition of artefacts and attempted elimination by careful preparatory techniques, and (4) the interpretation of previously published work in the light of the present study.

Comparison of Replicated and Ground EM Specimens (Table I).—The replicas represented the surface of the undisturbed precipitate, whereas the ground specimens were prepared by placing a small quantity of dermis or collagen gel on the tip of a glass plunger, inserting it into a matched ground glass container, and gently grinding in 0.5 ml. of distilled water. (Grinding in neutral phosphate buffer did not alter the picture). The resulting milky sus-

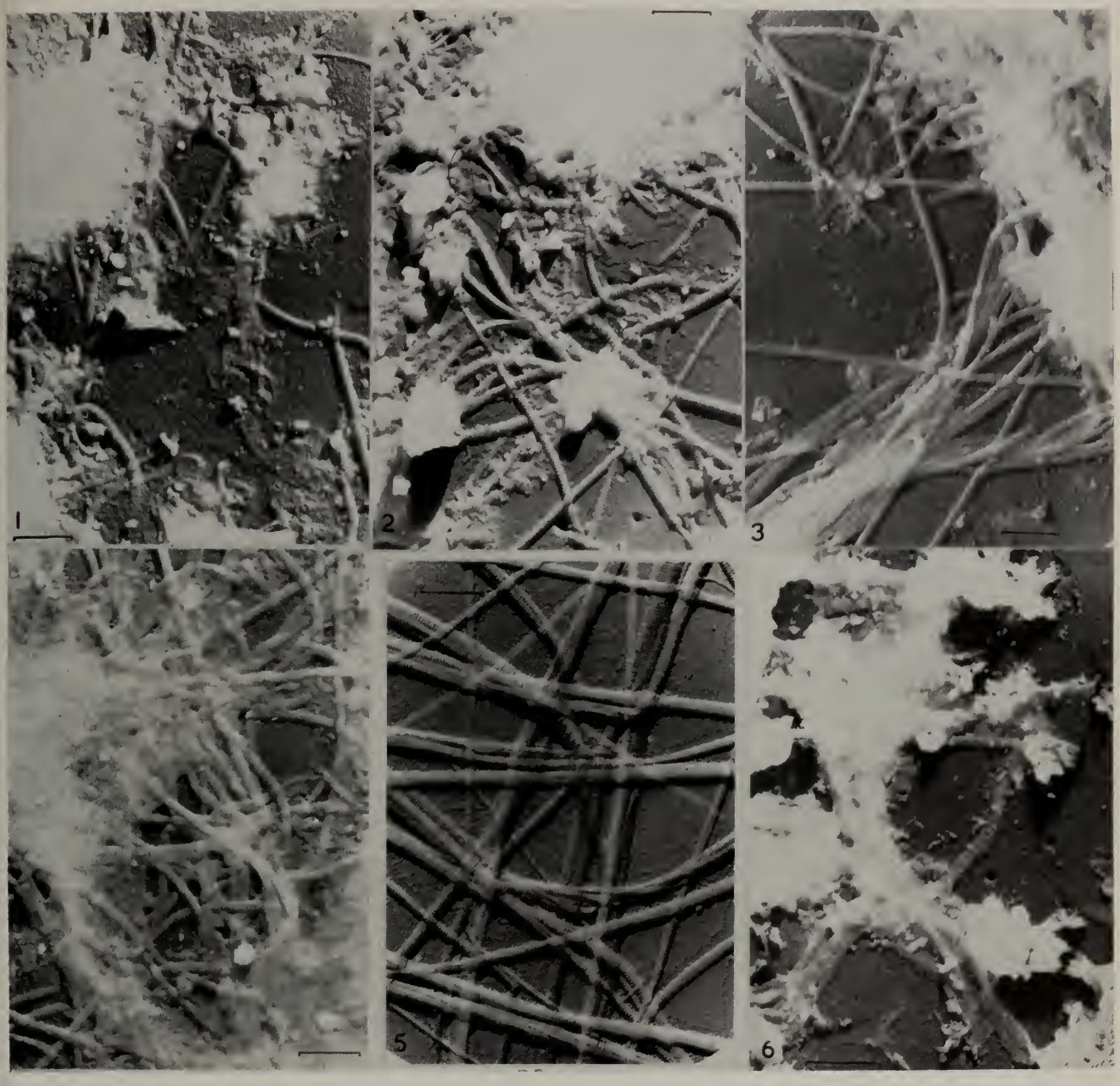


PLATE I

Figs. 1-4. Unfixed, fresh whole dermis from postmortem controls aged nine and sixty-three years. Fig. 1 shows typical child dermis after grinding three times, with narrower fibrils and more amorphous material than in the adult. After grinding twenty times (Fig. 2) the only change was a slight increase in dense bits and amorphous material. Similarly, comparison of the adult dermis ground three and twenty times (Figs. 3 and 4) only revealed a slight increase in amorphous material and dense bits with good preservation of the collagen fibrils.

Figs. 5 and 6. The replicated undisturbed control reaction mixture (Fig. 5) consisted of a network of collagen fibrils 1,000-1,400 A° in width. After grinding (Fig. 6) there was a decrease in collagen and appearance of amorphous material, dense bits and scanty "elastin." No tapered fibril ends or tactoids were seen.

Note: *The scale marked on all the figures represents 1μ. The replicas were shadowed with gold palladium and the ground specimens with chromium. All the striated structures exhibited 640 A° cross-banding, and all experiments were conducted at room temperature unless otherwise stated.*

pension contained solid particles which aggregated to form a "core" too large for EM examination. Samples of the surrounding finer suspension were examined in the usual way. Thus, several factors contributed to the decrease in collagen observed in the ground samples of re-precipitated collagen (Table I) as compared with their corresponding replicas: dilution, the hard "core" remaining in the grinder and the probable loss of some of the more unstable re-precipitated collagen by disintegration into amorphous material and, possibly, "elastin." The dilution factor was kept as constant as possible and the density of the ground deposits on the grids was approximately the same for all experiments. A "core" formed with all the substrates employed, and represents a disadvantage inherent in the grinding technique. However, if other factors are kept as constant as possible, examination of the surrounding suspension from different samples are comparable in respect to particle size, ease of separation from the parent tissue and the like, but not necessarily in respect to the relative quantities of collagen and elastin observed.

Amorphous material was absent in the replicas but present in the ground preparations. There was *no* significant increase when grinding was increased four-fold and seven-fold, and the untreated postmortem dermis showed the usual variation with age in spite of prolonged grinding. Its appearance and situation makes it highly probable that part of it was derived from degenerate, unstable collagen. The abnormal collagen re-precipitated in the presence of very small quantities of heparin and DNA was so unstable that even grinding three times rendered it degenerate and difficult to measure (Table II). In contrast, the postmortem collagen fibrils, or those precipitated in the presence of CSA or at a higher temperature (37° C.) were well-preserved even though ground twenty times (Table I), although these preparations still contained some amorphous material. As pointed out in previous publications,[13,15] material appearing amorphous in the electron microscope may vary both in chemical composition and source. In the present work it could derive from breakdown of unstable fibrils, or, in fresh tissue, it may represent the normal inter-bundle matrix or release of interfibrillar material from within the collagen bundles during grinding. Thus its presence in *ground*, and its absence in *replicated* samples of the same material is very understandable and must be taken into consideration when interpreting EM results. However, the fact that there was *no* significant increase with increased grinding, and that the postmortem dermis exhibited the usual variation with age, renders *comparison* of normal and pathological specimens valid *(vide infra)*.

Like amorphous material, *dense bits* were a constant feature after grinding (Table I). They were very scanty in normal, fresh dermis and the re-precipitated collagen ground three times but, unlike the amorphous material, their numbers increased as grinding was prolonged. As pointed out in previous publications,[15,19] the dense bits seen in the electron microscope may represent fragments of different structures depending on the experimental conditions and substrates used. For example, they may be a breakdown product of collagen (especially after treatment with alkali); of "moth-eaten" fibres (MEF); of the large, dense square-ended fibres found in normal fresh dermis[18]; particles of the ground connective tissue fibres described by Cruise,[6] or sections of the thick elastic fibres found in ox ligamentum nuchae or aortic media.[13] They increase in number (and may decrease in size) as grinding proceeds, and, under certain circumstances, they may be incorporated into newly-formed structures.[19]

The fact that addition of CSA and heparin did *not* increase the *elastin* counts over the control value (see Table I)—a comparable small amount being evenly distributed over all the grids of the re-precipitated collagen experiments—suggests that these substances are not necessary for its formation. The "elastin" counts were *not* significantly increased by the more prolonged grinding and this important finding is discussed later in relation to previously published work. The *absence* of elastin-like material in all the undisturbed replicated precipitates is presumably due to the absence of elastin in the collagen solutions employed. These collagen solutions were prepared from calf dermis by exhaustive extraction —first with salt and then with acetic acid, followed by dialysis of the acetic acid extract against 0.1 M NaCl to give a clear, viscous solution with a collagen content of about 0.1 per cent. The deposit re-precipitated by the addition of phosphate buffer alone or in the presence of small amounts of added substances, had *no* elastin-like material if left undisturbed, but a small quantity appeared after grinding in every case. Most of the pieces of "elastin" were small, resembled "skin-type" elastin[19] and, as stated under Methods, required frequent examination under the high-power eye-piece to ensure their identity. Thus, this evenly-distributed, four to eight pieces

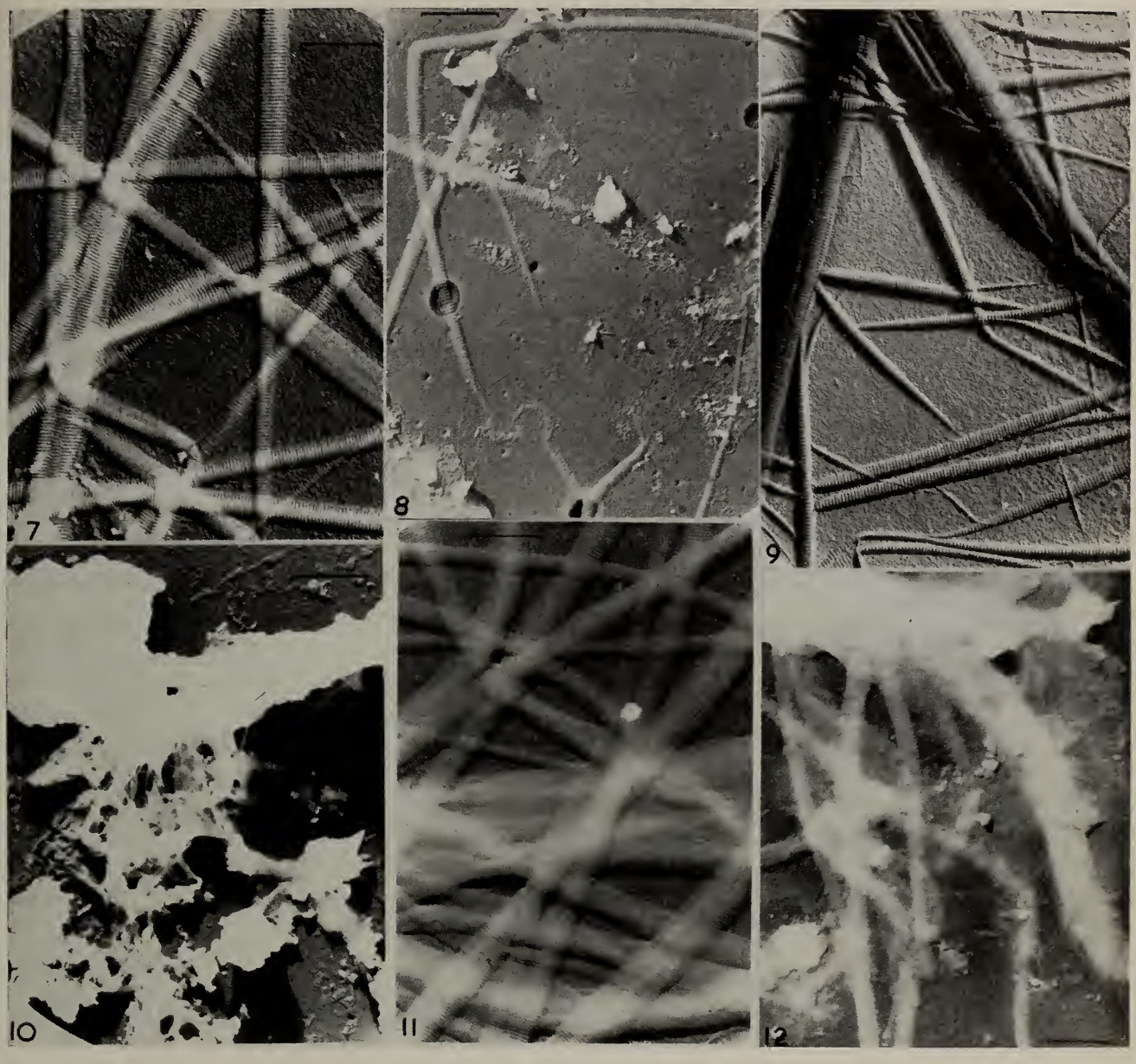


PLATE II

Figs. 7 and 8. The majority of the replicated collagen fibrils re-precipitated in the presence of ribonucleic acid (RNA) were 2,000-3,000 A° wide and exhibited acute fibril bends and tapered ends (Fig. 7). After grinding the collagen was decreased but some tactoids and tapered ends could still be seen (Fig. 8) accompanied by the appearance of amorphous material, dense bits and scanty "elastin."

Figs. 9 and 10. The replicated undisturbed reaction mixture (Fig. 9) re-precipitated in the presence of desoxyribosenucleic acid (DNA) consisted of abnormal, wide, striated structures; short slender tactoids 600-1,000 A° in width, and non-striated background filaments. After grinding (Fig. 10) the deposit consisted mainly of dense bits with some amorphous material and "elastin," the scanty collagen being frequently coated with amorphous material. No tactoids, wide fibres or tapered fibril ends were seen.

Figs. 11 and 12. The replicated undisturbed control reaction mixture (Fig. 11) consisted of a dense network of collagen fibrils 2,000-3,000 A° in width that exhibited marked lateral aggregation. After grinding three times (Fig. 12) the collagen was decreased in amount, and both striated and degenerate wide fibrils were mixed with amorphous material, a few dense bits and scanty "elastin."

per 25 fields appears to be an artefact consequent on mechanical manipulation of the reaction mixture, with *no* significant increase after prolonging the grinding up to seven-fold. Since no known elastin component was present in these experiments, it is presumed that a small fraction of the re-precipitated collagen less stable than the rest (possibly the most recently-formed), had become denatured to form these structures.

In the samples of untreated fresh dermis, the amount of elastin varied with age but not with prolonged grinding, and the counted structures conformed to the previously described morphologic range.[18,19] No chemical assessment was made.

A widely-used method of preparing EM specimens is homogenisation in a Waring blendor. As pointed out,[14] the temperature has to be carefully regulated —otherwise, thermal denaturation of the fibrils (especially those from young or growing tissue) will occur. No evidence of thermal change was seen in any of the present or previously reported work employing gentle grinding as an EM technique.

The Stability of the Collagen Fibril (Table I).— It has frequently been stressed that fibrils morphologically typical of collagen can be formed *in vitro* in the absence of cells, enzymes, or ionic salts.[10,20] However, little has been said about the relative *stability* of fibrils re-precipitated by different methods as compared with fresh dermal collagen. Although this investigation was primarily an attempt to compare two different methods of preparing the same experimental material (re-precipitated collagen) for EM examination with a view to evaluating any artefacts produced, it became evident that certain morphologic features correlated with the ability of the fibrils to withstand the mechanical stress imposed by the second technique, namely grinding. As described under the paragraph headed *Amorphous material*, the long, narrow, rigid fibrils re-precipitated in the presence of CSA or at 37° C. were well-preserved even after being ground twenty times, whereas most of the abnormal, wide structures formed with heparin and DNA were altered after grinding only three times. The stability of the low-temperature control and RNA deposits were intermediate between these two extremes. As detailed under Terminology, the morphologic features were classified into grades, *Grade 3* resembling adult, fresh dermis. The most important criteria appeared to be the width, length and rigidity of the re-precipitated fibrils (Table II). The closer the deposit approximated to the morphology of adult, fresh dermis, the greater the capacity to withstand mechanical stress. The post-mortem collagen remained well-preserved after grinding.

Recent work on the rate of precipitation of the collagen examined in the present study[25,26] revealed that factors which speeded up collagen precipitation (CSA, increase in temperature, . . .) produced a *Grade 3* deposit, whereas factors such as DNA and heparin, which markedly delayed precipitation, gave a *Grade 1* deposit. Body temperature ensures that collagen is formed at 37° C. and this study suggests that very small fluctuations in the amount of normal connective tissue constituents such as CSA and heparin, or an imbalance of the RNA-DNA systems (and their respective enzymes) within the cells, may have far-reaching effects on the products of the fibroblast and, hence, on the stability of the collagen formed.

Recognition of Artefacts and Attempted Elimination by Careful Preparatory Techniques.—In order to obtain reproducible results when re-precipitating collagen from solution, Vanamee and Porter[24] stressed the importance of carefully reproducing not only the concentration of collagen, hydrogen ions, and the like, but also any physical aspects of the technique that would tend to disturb the fibre formations during and after their development. Gross[9] also noted that apparently identical experiments using solutions of ichthyocol did not reproduce the same intermediate morphologic stages. In the present study, the re-precipitated collagen experiments employed the substrates and methods recently described by Wood and the author.[26] The following information was gained from mistakes in technique in the early stages of the work, and were omitted from the published results. These mistakes, however, are pertinent to the present investigation and serve to emphasize the vital importance of using freshly-made collagen extracts, uncontaminated solutions, the avoidance of heat when drying the specimen for EM examination, and the necessity for the exact reproduction of every aspect of experimental procedure in order to obtain comparable results.

1. The reaction mixtures intended for replication were dried in a stream of air at room temperature at the same distance from a small hair dryer. One sample was dried in a current of warm air. The deposit contained a large number of thick, twisted, rope-like, non-striated fibrils (Plate V, Fig. 28), which were absent from the remainder of the series

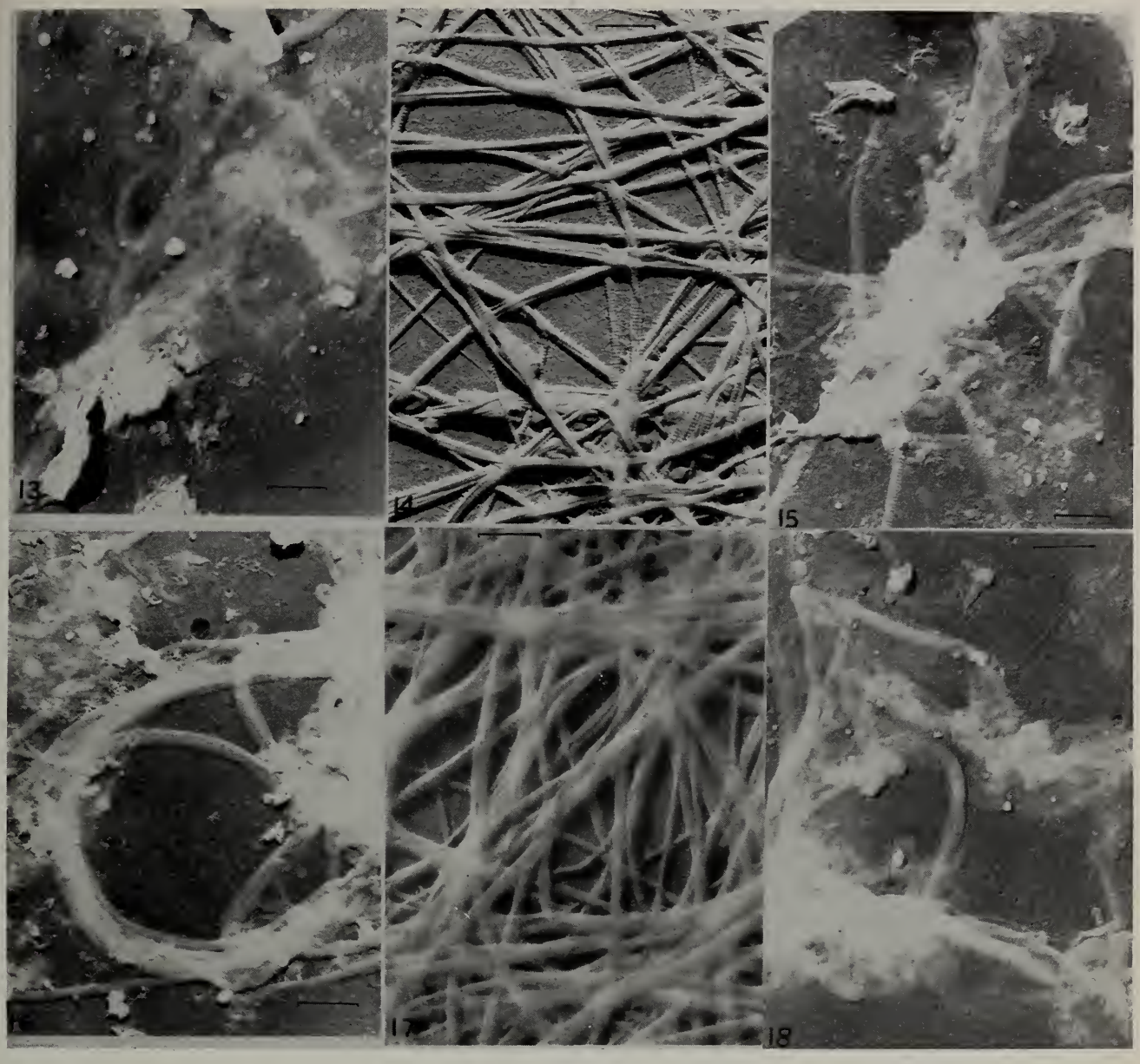


PLATE III

Fig. 13. Same experiment as Figs. 11 and 12 after grinding twelve times. The deposit was unchanged apart from a slight increase in dense bits.

Figs. 14-16. The undisturbed reaction mixture (Fig. 14) re-precipitated in the presence of purified chondroitin sulphate (CSA) b consisted of a very dense felt-work of rigid, narrow collagen fibrils 600-1,000 A° in width. After grinding three times (Fig. 15) the collagen was decreased in amount but the narrow fibrils were well-preserved though mixed with amorphous material, dense bits and scanty "elastin." After grinding twelve times (Fig. 16) the deposit was unchanged except for a moderate increase in dense bits.

Figs. 17 and 18. Comparison of replicated and ground collagen re-precipitated in the presence of CSA c. As with CSA b, the collagen fibrils were well preserved after grinding three times (Fig. 18).

and also from a repeat experiment dried at room temperature. It is possible that forming collagen has a lower shrinkage temperature than formed collagen, so that the mild heat produced was sufficient to induce the morphological picture of thermal shrinkage which is characterised by tactoidal separation and rope-like changes in the fibrils (Reed, unpublished results). This is in agreement with Brown and her associates[4] who reported that the shrinkage temperature of rabbit acid soluble collagen was low (41-45° C.).

2. The fact that the length of time the collagen

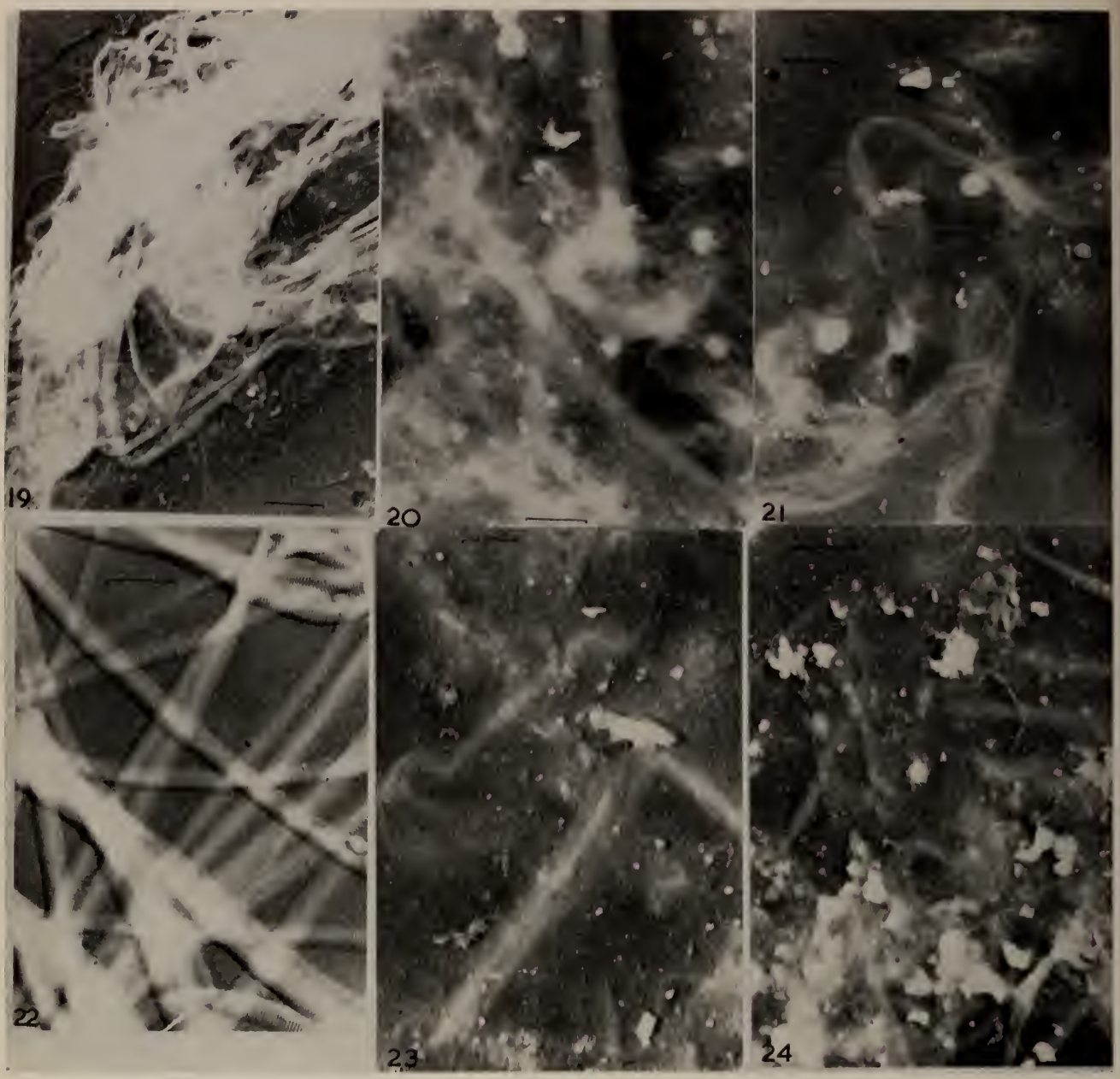


PLATE IV

Fig. 19. Same experiment as Figs. 17 and 18 after grinding twenty times. The fibrils are well-preserved and non-striated background filaments are prominent.

Figs. 20 and 21. The undisturbed reaction mixture (not illustrated) re-precipitated in the presence of 0.0005 per cent heparin, consisted of a dense network of immature collagen *(Grade 1)* with no dense bits, amorphous material or "elastin." Grinding three times (Fig. 20) rendered the collagen fibrils too degenerate to measure. They were mixed with amorphous material, scanty "elastin" and a few dense bits, the latter being increased after grinding twelve times (Fig. 21).

Figs. 22-24. The replicated undisturbed control reaction mixture re-precipitated at 21° C. (Fig. 22) consisted of a dense network of collagen fibrils 2,000-3,000 A° in width exhibiting marked lateral aggregation. After grinding three times (Fig. 23) the collagen was decreased in amount, and both striated and degenerate wide fibrils were mixed with amorphous material, a few dense bits and scanty "elastin." After grinding twenty times (Fig. 24) the deposit was unchanged apart from a moderate increase in dense bits.

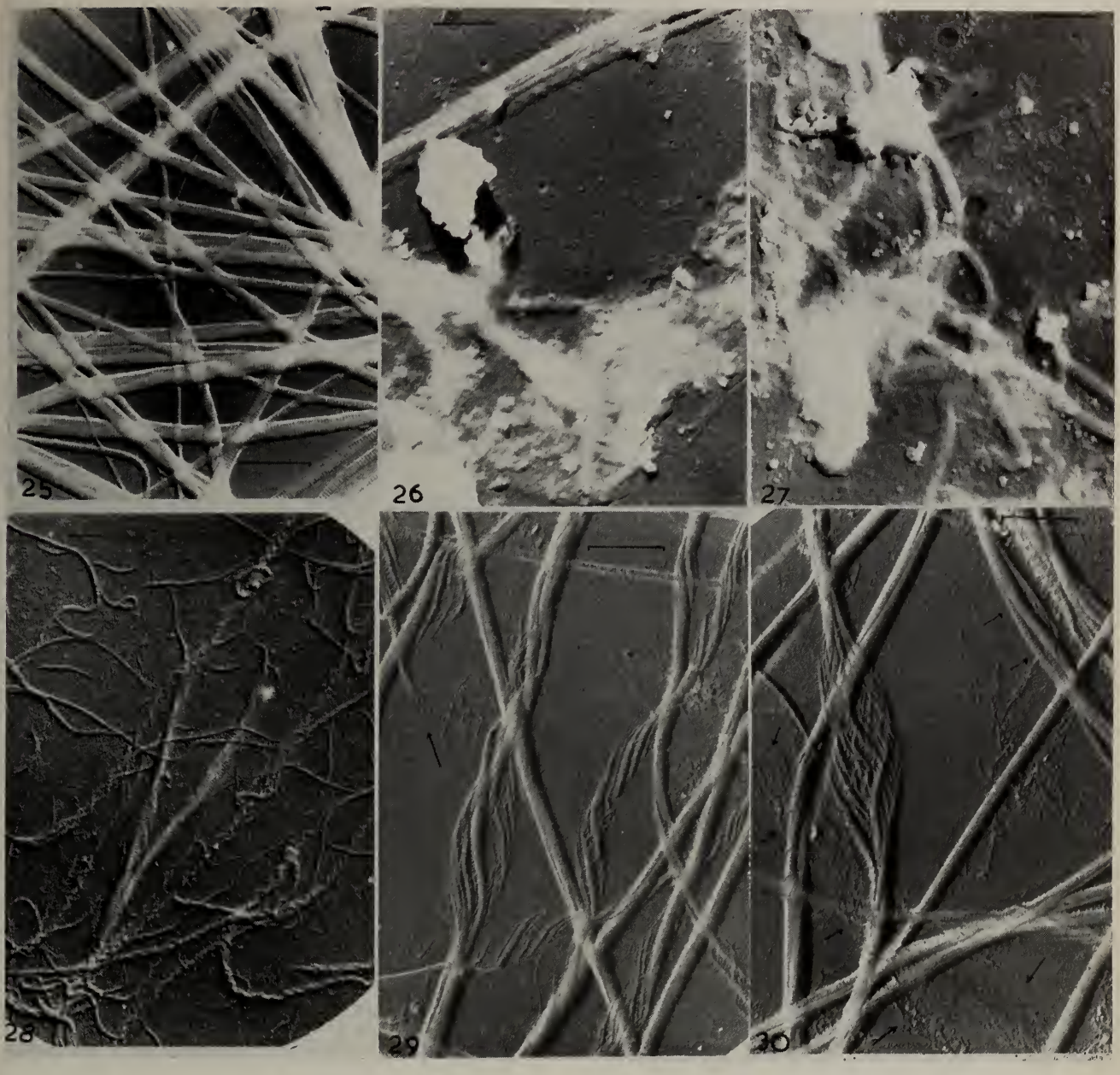


PLATE V

Figs. 25-27. The replicated undisturbed control reaction mixture re-precipitated at 37° C. (Fig. 25) consisted of a dense network of rigid, narrow collagen fibrils 1,000-1,400 A° in width. After grinding three times (Fig. 26) the collagen was decreased in amount but the narrow fibrils were well-preserved though mixed with amorphous material, dense bits and scanty "elastin." After grinding twenty times (Fig. 27) the deposit was unchanged apart from a moderate increase in dense bits.

Fig. 28. One set of reaction mixtures was dried with the hair dryer switched to "hot" before replication (see text). The non-striated background fibrils and filaments were twisted to form rope-like structures and the striated fibrils were partially separated into tactoidal components. These characteristics of shrinking collagen were absent from all the other experiments dried with the hair dryer at "cold."

Figs. 29 and 30. This replicated control reaction mixture was grossly contaminated and contained many collagen fibrils resembling un-ravelled ropes. This was presumably due to organismal attack and was not found in *un*infected repeat experiments. The early stages of attack can be seen at upper left, Fig. 29 (frayed fibril ends) and upper right, Fig. 30 (arrows). The final disintegration is shown as a band of crossed filaments (lower left) similar to the crossed helical array of filaments found after collagen breakdown by acid or alkali.[21]

solution had been stored affects the rate of collagen precipitation was briefly noted by Wood and Keech.[26] Spontaneous re-precipitation of collagen occurs very slowly in extracts stored at refrigeration temperature, the rate varying from batch to batch. One collagen solution formed a macroscopic precipitate after one month at 4° C. and EM examination revealed numerous striated collagen fibrils, occurring singly or in bundles. The majority measured 1,000-1,400 A° in width, but a few narrower examples were seen.

3. The importance of using uncontaminated solutions was demonstrated by using a collagen extract that had been stored at 4° C. for two weeks, but had (unknown to the writer) become contaminated. (Unfortunately the usual antibiotic preservative could not be employed since it precipitated the DNA and RNA). The experiments kept at room temperature for nine and twenty-four hours were grossly infected so that it was difficult to find a microscopic field to photograph without organisms. The control twenty-four-hour sample contained numerous frayed fibres not seen in any uncontaminated deposit (Plate V, Figs. 29 and 30). The collagen fibrils, presumably as the result of organismal attack, appeared as unravelled ropes of component tactoids, and resembled the breakdown of collagen by acid or alkali.[21] Repeat experiments using new solutions (no organisms being seen under the EM in the twenty-four-hour preparations) did not contain any of these frayed fibres.

Interpretation of Previously Published Work In the Light of the Present Study

Untreated normal and pathological dermis and normal dermis (after various physical and chemical procedures) have been examined using grinding as the method of disintegration. "Elastin" counts have been made and particular attention drawn to the variation in fibril width and relative amounts of amorphous material and "elastin" found in various conditions.[13,15,16,18,19] In view of the fact that the present study revealed that mechanical manipulation of re-precipitated collagen produced certain artefacts, it was considered necessary to examine fresh dermis under the same controlled conditions, in order to assess the action of grinding and any influence it might have had on the interpretation of previously published work. The experiments on untreated, postmortem dermis were therefore performed and included in the tables for comparative purposes.

The present investigation demonstrates that grinding does *not* affect the basic fibril width (Table II) and, although grinding produces some amorphous material and a very small quantity of "elastin" neither of these are significantly increased after prolonged grinding (Table I). It should be made quite clear that extremes were purposely used in the present investigation and that, in previously reported work, substrates were only ground three to six times, and only rarely six to nine times (if extremely hard) but certainly never twenty times. Thus, the *comparisons* of ground materials from different sources, both as regards fibril width, the amount of amorphous material, and the "elastin" content remains valid and independent of the number of times each was ground. For example, in the work on scleroderma,[16] a marked increase in amorphous material and a higher proportion of narrower fibrils were found in the pathological derma than in normal skin from the same patients or in controls of comparable age. The controls also showed the usual variation in amount of amorphous material with age. One is therefore on firm ground in stating that the conclusions drawn from reported work using ground material still hold good providing it is realised that the technique itself produces some amorphous material, dense bits and a very small quantity of "elastin" as outlined above. It should be borne in mind that the published work employed fresh whole dermis, which resists mechanical factors far better than the soft collagen gels used in the present study. It is presumed that in the latter, a small quantity of unstable collagen had become denatured to form the tiny structures counted, whereas in fresh whole dermis the normal range of elastin structures of differing size was encountered, and the amount varied with age but not with grinding.

Summary

Comparison of two methods of preparing electron microscope specimens is reported: the morphology of the replicated undisturbed reaction mixture and after disintegration in a tissue grinder. Fresh dermis and re-precipitated dermal collagen was examined and the production of artefacts evaluated. Measurement of fibril width and counts of elastin-like structures were made after grinding the same material three and twelve or three and twenty times.

It was concluded that replication is the method of choice when dealing with the soft gels of re-precipitated collagen, since these proved very sensitive to mechanical manipulation. Although grinding produced amorphous material and a constant small quantity of elastin-like material, neither was increased by increased grinding. The basic fibril width apper-

taining to each set of experiments remained unaffected by grinding.

The vital importance of strictly reproducing every aspect of experimental technique in order to obtain comparable results is emphasised, and several pitfalls are outlined.

Previously published work is reviewed in the light of the present study. It is concluded that *comparisons* of ground samples of normal and pathological dermis remain valid in respect to fibril width and relative quantities of amorphous material and "elastin."

A correlation was observed between the morphology and the stability of the collagen fibril. Collagen from fresh, adult dermis and the long, narrow, rigid fibrils re-precipitated in the presence of CSA or at 37° C. remained well-preserved after grinding twenty times. In contrast, the short, wide, abnormal collagens re-precipitated in the presence of DNA or heparin were rendered degenerate after grinding only three times.

Acknowledgments

Thanks are due to Dr. R. Reed for instruction in the replication technique and to Dr. G. C. Wood for material from his re-precipitated collagen experiments. I am very grateful to Professor R. E. Tunbridge, O.B.E., for his sustained help and encouragement throughout this work.

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Estimation of Plasma Fibrinogen Using Sodium Sulfite Fractionation

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THE ESTIMATION of fibrinogen is useful in the diagnosis, treatment and prognosis of various conditions such as acute myocardial infarction, hepatic disorders, and gangrenous lesions.[12] A direct correlation has been noted between the sedimentation rate of erythrocytes and the concentration of fibrinogen in the plasma in rheumatoid arthritis,[11] and a decrease in the concentration of fibrinogen has been used as an indication of the effectiveness of colchicine in the treatment of chronic gouty arthritis.[4] A rapid but reliable and simple method is needed, especially if hypo- or afibrinogenemia may be present, as in obstetrical patients with gross bleeding. The purpose of this study was to devise a simple rapid procedure.

Most methods for the quantitative estimation of fibrinogen are based on the separation of the protein in plasma by clotting with the aid of thrombin,[1,18] calcium,[3,7] or both.[10] These methods are complicated because the light-floating fibrin clot must be removed from the plasma pool and washed free from interfering proteins. This step increases the time required for determination and the extra handling tends to cause some loss in protein. The required time for precipitation of the fibrin clot by thrombin has been variously reported from ten minutes[14] to nineteen hours.[5] However, one hour appears to be the minimum time necessary for complete formation of clot with thrombin.[16,17] The thrombin reagent used for separation of fibrinogen is unstable and special attention must be given for its storage, thus further complicating the methods in which it is used.

Precipitation of fibrinogen by means of salt has been proposed by Howe[8] and Campbell and Hanna.[2] The latter workers used 12.5 per cent sodium sulfite solution and 0.5 ml. of plasma. Their results compared favorably with the calcium precipitation procedure of Cullen and Van Slyke;[3] in their procedure, the addition of sodium sulfite caused a precipitate in only one of 100 sera, the serum in the one instance having been from a patient with multiple myeloma. This method has apparently not been used frequently, owing to the amount of time and effort required for the destruction of fibrinogen by said digestion and subsequent conversion of the protein nitrogen to nitrate in measurements employing Nessler's reagent. This problem is obviated in the procedure described below by using the biuret reaction in which a red-violet color appears when a cupric salt is mixed with substances containing more than one $-CONH_2$ ion or -CONH- radical in their molecules and, hence, the reaction is given by proteins. This reaction is reported to yield more accurate results than the classic Kjeldahl procedure.[13]

Reagents

Sodium Sulfite Solution, 13 per cent. Dissolve 130 gm. of sodium sulfite in approximately 800 ml. of water in a 1-liter volumetric flask at 37-40° C. and make up to volume.

Trisodiumphosphate ($Na_3PO_4 12H_2O$), 5 per cent aqueous solution.

Cupric Sulfate ($CuSO_4 5H_2O$), 4 per cent aqueous solution.

Stock Standard Solution of Protein. Dilute 25 per cent normal human serum albumin* (salt-poor) to approximately 1.0 gm. per 100 ml. with 0.85 per cent sodium chloride solution. Determine the concentration of protein either by biuret or Kjeldahl analysis. Keep the solution refrigerated.

Diluted Standard Solutions of Protein. Pipet 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, 7.0, 8.0 and 9.0 ml. of the stock standard solution of protein into a 10-ml. volumetric flask and dilute to the mark with 0.85 per cent sodium chloride solution. Mix well and refrigerate.

Oxalated Tubes. Vacutainer** tubes, 7 ml. capacity, containing 20 mg. of potassium oxalate.

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*Division of Laboratories, Michigan Department of Health, Lansing, Michigan.

**Becton, Dickinson and Company, Columbus, Nebraska.

Collection of Specimen. Withdraw 7 ml. of venous blood, place in Vacutainer tube after removal of rubber stopper. Replace stopper on tube and mix well. This step is necessary in order to reduce hemolysis. Heparinized tubes, prepared by placing 0.5 ml. of Heparin Sodium‡ (100 U.S.P. units per ml.) into 12 by 100 mm. blood collection-tubes and then wetting the inner surface of the tubes and decanting the excess, were found to be good for this purpose.

Procedure

In a clean 15-by-120 mm. pyrex, leak-resistant, screw-cap tube calibrated at the 8 or 10 ml. mark with water, place exactly 1.0 ml. of oxalated or heparized plasma obtained by centrifugation of blood collected as outlined above. Add 9.0 ml. of 13 per cent sodium sulfite solution, mix, and stand the tube in a waterbath at 37° C. for ten minutes. A white precipitate forms which aggregates into larger masses. Centrifuge at 3,000 r.p.m. for five to ten minutes. The precipitate will collect in the bottom of the tube in a compact mass, leaving the supernatant fluid clear. Pour off the supernatant fluid and drain the tube for one minute, wiping off the last drops clinging to the mouth of the tube with absorbent tissue. Break up the precipitate by spurting in 5 ml. of the sodium sulfite solution. Place caps on the tube and shake vigorously to suspend the precipitate. Remove the cap and add 3 ml. of sulfite solution, washing down the sides of the tube. Recentrifuge, pour off, and drain the tube. (A small film of fibrin will enclose the fluid level of the tube but will cling to the wall of the tube while the wash sulfite is being decanted). Add 8 or 10 ml. of 5 per cent sodium triphosphate solution to the tube. Place in a boiling waterbath and boil until the protein precipitate is dissolved. This usually requires ten to fifteen minutes. Cool the tube in a cold waterbath. Replace the evaporated basic solution to the 8 or 10 ml. mark. Add 0.2 ml. of 4 per cent copper sulfate to the tube stopper and shake vigorously for two or three minutes. Remove the cap and centrifuge at 3,000 r.p.m. for ten minutes. Decant the supernate and read in a suitable spectrophotometer at 560 mm. A water blank is determined along with the samples.

Standard Protein Solutions. Pipet 1 ml. of the diluted standard solutions of protein containing 0.100, 0.200, 0.300, 0.400, 0.500, 0.600, 0.700, 0.800, and 0.900 gm., respectively, of protein. Add 7 or 9 ml. of 5 per cent phosphate solution, followed by 0.2 ml. of copper sulfate solution, and proceed as in determination of fibrinogen.

‡The Upjohn Company, Kalamazoo, Michigan.

TABLE I. COMPARISON OF AMOUNTS OF FIBRIN(OGEN) FOUND AFTER THROMBIN PRECIPITATION AND AFTER SALT FRACTIONATION PROCEDURES, USING POOLED PLASMA

Sample No.	Grams of Protein per 100 ml.		Plasma Found by Designated Method	
	Thrombin Ppt	Sodium 13 per cent	Sulfite 12.5 per cent	Ammonium Sulfate Turbidimetric Method[6]
1	0.594	0.594		0.487
2	0.520	0.544		0.670
3	0.460	0.480		0.430
4	0.476	0.480		0.538
5	0.370	0.355		0.492
6	0.368	0.380		0.511
7	0.500	0.490		0.740
8	0.440	0.440		0.708
9	0.480	0.478	0.500	0.583
10	0.503	0.485	0.465	0.575
11	0.480	0.460	0.425	0.603
12	0.590	0.590	0.575	0.590
13	0.490	0.490	0.490	
14	0.445	0.430	0.460	
15	0.540	0.560	0.490	
16	0.495	0.490	0.490	
17	0.565	0.560	0.565	
18	0.660	0.660	0.635	
19	0.585	0.580	0.560	
20	0.610	0.608	0.565	
21	0.612	0.617	0.585	
22	0.730	0.730	0.645	
23	0.520	0.540		
24	0.500	0.520		
25	0.550	0.570		
26	0.516	0.516		
27	0.530	0.550		
28	0.560	0.570		
29	0.480	0.480		
30	0.610	0.605		

Results and Discussion

Table I lists the comparative results of the sodium sulfite precipitation (using two different concentrations of sodium sulfite), a thrombin precipitation method, and Fowell's[6] modification of the Parfentjev turbidimetric method.

In the thrombin precipitation method the clot was allowed to form during a two-hour period after the addition of 200 NIH (National Institutes of Health) units of thrombin.[9] Calcium chloride (0.1 ml. of 2 per cent solution) was added along with the thrombin to 1 ml. of plasma in 4 ml. of 0.85 per cent saline solution. The clot was broken by vigorous agitation and centrifuged at 3,000 r.p.m. for fifteen minutes. The light-floating clot was collected and washed on a gooch crucible, size 3, fitted with Whatman No. 42 filter paper connected to a suction funnel. Both clot and paper were placed in 8 ml. of 5 per cent phosphate solution contained in a pyrex screw cap tube and the procedure carried out as outlined for the sodium sulfite fractionation method.

The values of the thrombin precipitation method and 13 per cent sodium sulfite fractionation procedure

agree within 10 milligrams in 60 per cent of the samples. The *t* value of both series (1.00) indicate that the two methods are different, but the difference between the individual values produced an error of 0 to 4.13 per cent.

TABLE II. REPRODUCIBILITY OF 13 PER CENT SULFITE FRACTIONATION PROCEDURE FOR FIBRINOGEN, USING POOLED PLASMA

Sample No.	Grams of Fibrinogen per 100 ml. Plasma Found in Replicate Specimen						
1	0.372	0.372	0.372	0.372	0.368	0.368	0.368
2	0.297	0.300	0.300	0.301	0.305		
3	0.432	0.432	0.436	0.438	0.438		
4	0.396	0.396	0.390	0.394			
5	0.432	0.432	0.437	0.435	0.437		
6	0.391	0.396	0.393	0.392	0.391		

The difference in values between the 13 per cent sulfite and 12.5 per cent sulfite fractionation methods indicate that the 13 per cent sulfite concentration is critical and must be adhered to during analyses. Preliminary determination in which the sulfite concentration was decreased to 12, 11.5, and 11 per cent caused a decrease in the amount of protein fractionated from plasma during a ten-minute period of incubation. Increasing the concentration of sodium sulfite to 13.2 per cent produced no change in the amount of protein fractionated from plasma.

TABLE III. RECOVERY OF ADDED FIBRINOGEN TO SERUM, USING 13 PER CENT SULFITE FRACTIONATION PROCEDURE

Amount of Fibrinogen Added (gms. per 100 ml.)	Amount of Fibrinogen Recovered (gms. per 100 ml.)	
	Sodium Sulfite Method	Thrombin Method
0.380	0.380	0.373
	0.384	0.382
	0.380	0.380
0.230	0.230	0.215
	0.230	0.215
	0.230	0.230
0.180	0.180	0.180
	0.180	0.170
	0.180	0.180

The ammonium sulfate turbidimetric method gave results that were generally higher than either the thrombin or sulfite procedure. However, it must be kept in mind that the formula for calculating values in this case was empirically derived, having been based on 43 estimations using a Coleman model C spectrophotometer.[6]

All measurements in the method given above were made on a Coleman Junior model C and D spectrophotometer, using pooled plasma samples left over from plasma glucose and urea nitrogen analyses.

The precision of the procedure was tested by doing replicate analyses on six different batches of pooled plasma. The results of this study are given in Table II. The standard derivation for the six series was 7.03×10^{-3}, giving a standard error of 1.81 per cent for the average of the series with a range of 2.32 to 1.60 per cent within the series.

The results of the recovery study are given in Table III. Weighed amounts of pure human fibrinogen (Parenogen)§ were dissolved in nonlipemic, nonhemolyzed whole pooled serum. Aliquots of the reconstituted plasma were analyzed by both the salt fractionation and thrombin precipitation techniques.

TABLE IV. COMPARISON OF RESULTS OF RECOVERY OF PROTEIN BETWEEN WASHED AND UNWASHED PRECIPITATES USING THE 13 PER CENT SULFITE FRACTIONATION PRODECURE

Sample		Protein Recovered (gms. per 100 ml.)	
No.	Pair No.	Washed Ppt.	Unwashed Ppt.
A	1	0.482	0.563
	2	0.485	0.567
	3	0.488	0.585
B	1	0.490	0.585
	2	0.490	0.596
	3	0.492	0.597
C	1	0.495	0.600
	2	0.502	0.604
	3	0.508	0.610

The results of this study (Table III) indicate that slight losses may have occurred in the thrombin procedure. Both methods, however, agree very well.

In an effort to determine the amount of nonfibrinogen protein occluded or adhering in the initial protein fractionation with 13 per cent sodium sulfite solution, three samples of pooled plasma were determined in three sets of pairs. One tube from each pair was allowed to drain for twenty-five minutes on clean absorbent paper and the remaining tube was carried through the regular washing procedure. The amount of protein washed out is indicated in Table IV. An error of 14.8 to 17.5 per cent was introduced into the procedure by omitting the washing.

The effect of different anticoagulants on sulfite fractionation is shown in Table V. The plasma for this study was collected from members of the department of pathology at this hospital. Evaluation of these data indicates that the type of anticoagulant is relatively unimportant for collection of blood. Better correlation was attained with these individual samples than with pooled plasma, probably because of the

§Product of Cutter Laboratories, Berkeley, California.

absence of hemolysis, and the lesser concentration of chyle and bilirubin.

The sensitivity of the procedure is increased approximately 25 per cent by having the dissolved fibrinogen react with copper sulfate in a basic phosphate medium, rather than with a mixture of diluted Weichselbaum's biuret reagent.[15,16] This increase in sensitivity is desirable in measuring small quantities of protein. The increase in sensitivity is explained by the relatively low optical density of the phosphate containing reference solution (Fig. 1).

Summary

A sodium sulfite precipitation procedure is described for the determination of plasma fibrinogen. With 13 per cent sodium sulfite solution, fibrinogen may be rapidly salted out of plasma—obtained from oxalate citrate, heparin, or ethylene-diamine-tetra-acetic acid (EDTA) treated blood. The protein concentration is estimated by the biuret reaction. The values compare well with those obtained with a more tedious thrombin precipitation procedure.

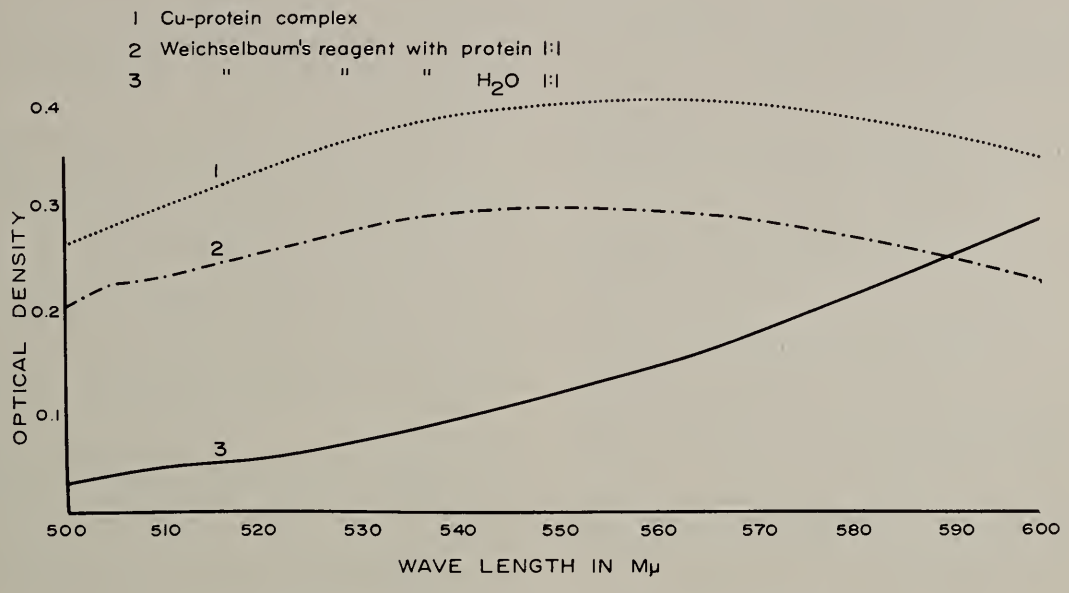


Fig. 1. Absorption spectra of the copper-protein complex.

TABLE V. EFFECT OF ADDITION OF DIFFERENT ANTICOAGULANTS IN SAMPLES OF 8 ML. OF BLOOD ON ESTIMATION OF FIBRINOGEN

Sample No.	Grams of Protein Found Per 100 ml. Plasma After Addition of Specified Amount Anticoagulant					
	Potassium	Oxalate	Disodium	EDTA*	Heparin**	Sodium Citrate
	20 mg.	40 mg.	10 mg.	20 mg.		80 mg.
1	0.300	0.303	0.298	0.300		
2	0.300	0.295	0.310	0.310		
3	0.300	0.300	0.305	0.305		
4	0.323	0.323	0.323			
5	0.337	0.337	0.335	0.335		
6	0.315	0.315	0.320	0.320		
7	0.400	0.400	0.405			
8	0.338	0.338			0.318	
9	0.365	0.365			0.360	
10	0.300	0.298			0.290	
11	0.328	0.320			0.328	
12	0.352	0.352			0.350	
13	0.348	0.346			0.348	
14	0.275	0.282			0.282	
15	0.450					0.460
16	0.345					0.348
17	0.315					0.310
18	0.340					0.343
19	0.360					0.360
20	0.317					0.317

*Ethylene-diamine-tetra-acetic acid.
**The tubes were coated with Heparin containing 100 units per ml.

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Oral Polio Vaccine Approved

After seven years of laboratory study and extensive field trials around the world, the live-virus polio vaccine developed by Albert B. Sabin, M.D., of the University of Cincinnati was selected by the U. S. Public Health Service as suitable for use in the United States.

The Sabin vaccine thus became the second polio preventive resulting from a research program paid for directly by the American public.

Following a joint project with Manuel Ramos-Alvarez, M.D., in Toluca, Mexico, Dr. Sabin reported success in something never attempted before—elimination from a large population group of certain naturally occurring viruses by rapid mass giving of live-virus vaccine.

Normally, at any given time, a high percentage of Toluca children are harboring (in their intestinal tracts) wild polio viruses. About 86 per cent of these children under age eleven were fed Sabin live-virus polio vaccine in a very short period of time. The result was that the live (but tamed) vaccine viruses literally overwhelmed the other polioviruses and the latter temporarily disappeared.

The study indicated that rapid and mass live-virus vaccine feeding may serve as a new and effective approach to disease control on a community basis.

(Editor's Note: Dr. Albert B. Sabin's paper on "Vaccines Against Polio" presented at the Michigan Clinical Institute, March 11, 1954, was published in this Journal September 1954, page 985. At that time, the Editor talked with him, and he anticipated his vaccine would soon be ready for distribution; he was already testing it. The preceding quotations were from a news release of The National Foundation.)

Symposium on the Present Status of the Clinical and Therapeutic Knowledge Of Some Rheumatic Diseases

Report by Ezra Lipkin, M.D.
Detroit, Michigan

BETWEEN October 19 and 23, 1960, it was my pleasure and privilege to attend a Symposium on Rheumatic Diseases, arranged by the Mexican League against Rheumatism, in conjunction with some members of the Pan-American Medical Association, at Ixtapan, Mexico. Represented at this Symposium were some of the outstanding luminaries in the medical profession, particularly in the field of Rheumatology. This report will perforce be a sketchy one. Nonetheless, it will attempt to convey the salient points brought out by the various speakers, and dwell upon the highlights with which the general practitioner may or may not be familiar. While a good deal of the material may be didactic, it represents the experience of the speakers, both in the clinical and laboratory fields. In spite of the general agreement as to the value of steroid therapy, there were some areas of disagreement, which made the panel discussions both provocative and vital. This report will be as objective as possible, and will, at times, give verbatim quotations of the speakers' statements. The lectures will be summarized in the order in which they were given.

The first group of lectures dealt with corticosteroids —their chemistry, physio-pharmacology and therapeutic applications—also the contraindications, complications and risks in their use. Omitting the first two papers, because of their highly technical nature, I shall begin with a review of the third paper.

Contraindications, Complications and Risks in the Use of Corticosteroids

By Dr. Maxwell Lockie, Head of the Department of Therapeutics, University of Buffalo School of Medicine, Buffalo, New York.

Steroids should not be used for more than fifty days. In rheumatoid arthritis, minor tissue changes are reversible, major ones, not. Major changes may go on to death.

Side Effects.—Hypercortinism—moon face, striae, acne, edema—electrolyte disturbance. *Retention of sodium* leads to edema, which can be treated with oral or intramuscular diuretics. *Potassium depletion,* as manifested by weakness, nausea, vomiting and diarrhea, and shock, can be treated by the administration of potassium chloride. Bananas have a large amount of potassium. *Disturbance of calcium metabolism:* excessive excretion causes osteoporosis. The use of milk is indicated. Estrogen and androgen must be given. There is impairment of connective tissue repair. There is produced a negative protein balance.

Principal Contraindications.—Tuberculosis (steroids may be used along with medication for tuberculosis), systemic infections, peptic ulcer, and hypertensive vascular disease.

Steroid Diabetes.—Diabetics can tolerate steroids for a long time. There is a decrease in glucose tolerance in non-diabetics.

Osteoporosis.—X-rays are not always reliable. The post-menopausal female patient must be on long-term therapy.

Peptic Ulcers.—new or reactivated—patients must be on long-term therapy. There is hazard in 25 per cent of the cases. Repeated red blood cell counts must be taken. There is a question of the value of keeping the contents of the stomach alkaline or neutral.

Stress, including Surgery.—It takes six to nine months to recover from adrenal suppression. If stress



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Organized by Members of the Pan-American Medical Association and the Mexican League against Rheumatism and held at Ixtapan, Mexico, October 19 to 23, 1960.

occurs after fifty days of steroid therapy, additional steroids must be given.

Elective Surgery.—If a patient has had steroids, or had stopped the medication within a year, a double amount of the former dose must be given—two days before surgery, one day before surgery, and one hour before surgery. After surgery, one-half dose is given for the first day, and a quarter dose the second postoperative day.

Emergency Surgery.—300 mg. cortisone at the time of surgery, 100 mg. during surgery, 100 mg. six to twelve hours after surgery, 100 mg. the first day after surgery, and 50 mg. the second day.

Psychosis and Psychoneurosis.—About 5 per cent. Most patients clear up after discharge from the hospital. Some may require shock therapy.

Effect of Steroids on Inflammatory Tissue.—Steroids suppress inflammation. Enough cortisone must be used to carry patient over the inflammatory period. The patient may have severe surgical complications, in which antibiotics may prove ineffective. Fever of unknown origin may be due to staphylococcus infection.

Excessive Fatigue, Aching.—Such conditions may simulate flare-up of arthritis, but actually may be due to hypercortisonism. The regular administration of the drug is important, as are rest and sedation (elixir alurate). There must be a gradual decrease of steroid administration.

Peripheral Neuropathy.—This is improved when steroids are decreased.

Ecchymosis and Necrotising Arteritis.—In these many patients respond to the new types of steroid.

There is loss in body weight and mass with the administration of triamcinolone. This needs clarification.

Withdrawal Symptoms.—Withdrawal must be very gradual, to where maintenance will give help.

Steroids always help, but the physician must use great caution.

Hormone Treatment of Rheumatoid Arthritis

By Dr. Joseph Bunim, Clinical Director, National Institutes of Arthritis and Metabolic Diseases, Washington, D. C.

Instead of steroids, initial treatment for rheumatoid arthritis should include reassurance, explanation, resolving emotional conflicts, rest, correct nutritional state, analgesics, correction of deformities (physiotherapy, splints, corrective exercises). If these fail, after several months, use gold and steroids, anti-malarial agents. Steroids should not constitute the only drug. The physician should use a comprehensive program survey of patient for evidence which might contraindicate steroids, such as pertussis, tuberculosis, and peptic ulcer. The patient should be informed about the difficulty of withdrawing the drug. The physician should calculate the probabilities of the good effects of steroids. The dangers should outweigh the risks of giving steroids. Steroids cannot mobilize ankylosed joints or help atrophied muscles and fibrosis. We must be sure that the patient has a reversible disease, not an irreversible one. The side-effects may be formidable.

Indications for Steroid Therapy.—Rheumatoid arthritis which is progressive and threatens invalidism in a patient who has not responded to conservative treatment. If the course of the disease is accompanied by severe systemic disturbances, steroids are used over a short period to tide the patient over. There is not much superiority of one steroid over another. Steroids *are* more effective than aspirin.

STEROID DOSAGE

Steroid	Mg. Activity	Dosage
Cortisone	0.8	50-60 mg.
Hydrocortisone	1.00	40-50 mg.
Prednisone and prednisolone	3-4	10-15 mg.
Triamcinolone	3-4	4-14 mg.
Methylprednisolone	3-4	4-14 mg.
Dexamethasone	20-28	1- 4 mg.

Limitations of Steroid Therapy.—

1. In 40 to 50 per cent, after one year, the results diminish.

2. The difficulty of discontinuing steroid therapy—25 per cent develop withdrawal symptoms. For short duration (twelve weeks) there is no difficulty. Over twelve months, try to discontinue.

3. Steroids do not change course of disease, only suppress inflammation. ("A five-year follow-up shows this to be true"—Freyberg.) Lower amount of steroids by concomitant administration of large doses of aspirin; 3.6 gm. aspirin per day. In 75 per cent of cases, despite steroids, rheumatoid arthritis progresses.

Adverse Effects.—One of the most important effects on ulcer is size of dosage. The ulcer will heal on anti-ulcer regime. There is no telling when the patient will get an ulcer. The shortest length of time after steroid administration was three weeks—the longest, three years.

Osteoporosis.—compressed fractures—estrogen and androgen not always helpful. When intake of calcium

is increased to 1000 to 1800 mg. a day, the calcium balance is increased. We have no data on results.

Necrotising Arthritis.—polyarteritis nodosum or polyarteritis: The inflammation of small arteries is an essential part of the pathology of rheumatoid arthritis. There is an infiltration of round cells in the adventitia. With the use of steroid therapy, there has been increased evidence of patient's having polyarteritis nodosa. Try to withdraw steroid therapy in patients having such complications.

There is a relation between steroid therapy and increased incidence in complications—16 to 25 per cent.

Being bed-ridden is a contraindication to the use of steroids. Reduce dose, even if the patient is doing well.

Choline salicylate (liquid) gives best results, as far as ulcer is concerned.

Hormone Treatment of Other Connective Tissue Diseases

By Dr. Richard Freyberg, Director of the Department of Rheumatic Diseases, Hospital for Special Surgery, N. Y., Hospital Cornell Medical Center, New York.

Diffuse Collagen Disease.—"Diffuse Connective Tissue Disease" is a better term. It includes rheumatic fever, rheumatoid arthritis, lupus erythematosus, progressive systemic sclerosis (scleroderma). Other connective tissue diseases include osteoarthritis, non-articular rheumatism, traumatic and gouty arthritis, ankylosing spondylitis.

Osteoarthritis is a non-inflammatory degenerative disorder. Steroids have little value in this condition. They give some relief in hip and spine involvement in osteoarthritis. The incidence, however, is small. It may be used, if it gives relief, but it is not to be used generally. No steroids for pain—give salicylates. If there is synovitis (through friction of roughened surfaces) in knees or hips, much benefit is derived from the use of hydrocortisone—eight to twelve weeks apart. It is useful because of its anti-inflammatory effects.

Non-Inflammatory Rheumatism.—Bursitis, tendinitis, tendon attachment syndrome, tenosynovitis, periarthritis of the shoulder, frozen shoulder, lumbago, fasciitis. Aching, stiffness, and so forth, not due to inflammation. Systemically given steroids not effective. Localized fibrositis, bursitis—local intra-articular or intrathecal injections give good relief.

Not all joint pains are due to bursitis. They may be due to tendinitis. Injection into tendons may be irritating.

Multiple injections are not advisable. In periarthritis, a short period of steroids systemically may be helpful. 25-50 mg. daily.

Shoulder-Hand Syndrome follows visceral disease—intrathoracic pathology. Steroids may be given.

Lupus Erythematosus.—We are more aware of this condition since demonstration of LE cells. The major symptoms are visceral, not only arthritic. Exclude steroids as long as possible, because they are difficult to discontinue. Systemic lupus erythematosus requires large doses and continued therapy with steroids. Chloraquin has had moderate success in some cases.

In carditis, pericarditis, pneumonitis, steroids are required, and strongly advised. Prednisone 20 to 30 mg. daily. After fourteen days, reduce to maintenance dose of 10 to 15 mg. daily. With chloraquin derivatives, reduce amount of steroids. Ulcer and osteoporosis are the chief side effects. For prophylactic purposes, use a low caloric ulcer-type diet, antacids, antibiotics, calcium, a generous protein intake. Smoking is to be discontinued. If major surgery impends, use supplementary steroids. "Lupus nephritis is refractory to steroids"—this has not been his experience. In pregnancy, the use of steroids is indicated. In the acute crisis of systemic lupus erythematosus intravenous cortisone may have to be used.

Systemic lupus erythematosus is a potentially fatal disease. For a severe condition, large doses should be given, especially for visceral manifestations, not "too little or too late."

Hormone Treatment of Rheumatic Fever

By Dr. Javier Robles Gil, Chief of the Department of Rheumatic Diseases, National Institute of Cardiology, Mexico.

The problem is unsettled. In a group of commissurotomized patients, rheumatic activity was found: without treatment 67 per cent, with salicylates 66 per cent, with hormone treatment 33 per cent. With steroid therapy, life was prolonged in severe cases of rheumatic fever.

A series of experiments was performed on three groups of rheumatic fever. The first was very active, very recent; the second, very active, not so recent; the third, not active, of long standing. All were treated with steroids—35 to 40 mg. prednisolone—for three to four months. Results: Disappearance of pericarditis under steroid therapy: Group 1, 100 per cent; Group 2, 83.33 per cent; Group 3, 40 per cent. Disappearance of manifestations of rheumatic mitral valvulitis:

	Murmur (Per Cent)	*Rumble* (Per Cent)
Group 1	55	74
Group 2	8	38
Group 3	0	0

Should rheumatic fever be treated with steroids? Yes. Steroids are very helpful in controlling the inflammatory process. We cannot predict the evolution of rheumatic fever. It should be used in:

1. Rheumatic fever, active and recent, with some manifestation of visceral involvement; it will diminish lesion, even if there is no change in the evolution of the rheumatic process.
2. Rheumatic fever, active, not so recent, with recurrences.
3. Rheumatic fever with recurrences, in long standing myocarditis.
4. Rheumatic fever, in serious cases with prolonged fever, with no apparent activity (which, nevertheless, were found to have Aschoff bodies on commissurotomy).

Steroids should be used in fulminating cases of rheumatic fever in patients, who would otherwise die of salicylate intolerance or digitalis intoxication.

Local Treatment with Corticosteroids

By Dr. Joseph Hollander, Chief of Arthritis Section, Hospital of the University of Pennsylvania, Philadelphia.

After ten years, local treatment with corticosteroids has proved a valuable addition to the therapy of rheumatic diseases. Four thousand patients were treated with 100,000 injections of steroids.

The injections must be given *into* the synovial cavity, not near it.

Indications.—Every form of rheumatic disease, except where infection exists. Hydrocortisone acetate is more effective than cortisone.

Long-term Results.—As many as 100 injections were given into one joint. The maximum was 137 injections. The interval was one week or more. Prednisolone TBA was the most consistently effective steroid.

In one hundred cases of arthritic knees, findings were as follows:

No further symptoms	59
Still receiving treatment	24
Joint deterioration	7
Too transient relief	10

After four years of intra-articular steroid therapy, thirty-eight showed no deterioration of the knees.

Two per cent of the patients showed post-injection flare-ups.

There was no evidence of loss of sensation or function.

The injections gave purely symptomatic relief and have not stopped the ravages of the disease.

Braces have been used to support weight-bearing joints.

Hydrocortisone has become established as a local adjunct to the treatment of arthritis.

Application of Corticosteroids to Other Rheumatic Diseases

By Dr. Maxwell Lockie, Head of the Department of Therapeutics, University of Buffalo School of Medicine, Buffalo, New York.

Dermatomyositis.—There is acute muscle pain, weakness, edema or rash. The joint manifestations are suggestive of rheumatoid arthritis. There is calcinosis. Fatality, 50 per cent. There is a life expectancy of three years. There is an eosinophilia, creatonuria. The electromyograph is significant. There is fascial edema. The skin has an heliotrope color. Steroids are very important in this group. It is a connective tissue disease. An early and adequate trial with steroids should be undertaken.

Polyarteritis Nodosum.—Muscle biopsy is one-third positive. Males 3:1, in the twenty to fifty year span. Medium and small calibre vessels are affected with necrosis and infiltration of media. Mimics many systemic infections. Kidney involvement, abnormal urinary findings in 89 per cent of cases. Abdominal pain in two-thirds of the cases. There is enlargement of the heart. There are arthralgias rather than arthritis. There is involvement of the central nervous system. Cutaneous manifestations are present in 35 per cent of the cases. *Diagnosis*, in a patient of middle life, is made in less than half the cases. Hematuria, peripheral arthropathy, neuropathy, positive skin biopsy, low-grade fever—these are the cardinal symptoms. There is prompt response to steroids.

Scleroderma—related to Raynaud's disease. Easy to diagnose. Alimentary canal lesions. Myocardium and lungs may be involved. There may be renal lesions. There are calcium deposits in the skin, subcutaneous tissue, fascial planes. It is more predominant among females. There is stiffness of the hands, tightness of the skin of the palms, fibrosis. The muscles contract. There is difficulty in swallowing and breathing. There are subcutaneous nodules and calcifications. The laboratory tests are negative. *Management* consists in low roughage diet, reducing phosphate intake, trial with steroids, relaxin, paba, sympathectomy.

Panel Discussions

Hormone Treatment of Rheumatoid Arthritis

Dr. Freyberg: We are unable to alter the pathology of rheumatoid arthritis in the long run. After two years, there is a structural breakdown. We cannot give enough steroids to suppress the disease, in view of the side-effects. However, the patient is substantially better over a period of months or years.

In rheumatic fever, steroids may suppress the disease entirely.

In rheumatoid arthritis, use gold preliminary to steroids after conservative treatment if patient understands the limitations of steroids. Never start a patient on steroids. If steroids are discontinued after eighteen months, we have the same return of symptoms.

Dr. Hollander: If rheumatism is decompensated, use steroids. It may be a long-term therapy in some patients. In the long run, the patient is better.

Dr. Lockie: Dr. Bunim is on the conservative side. He is an enthusiast for gold, which can do as much as any other therapy. In visceral disease—pericarditis, pneumonitis—we need steroids as life-saving.

Dr. Dorfman†: Dr. Bunim is concerned with seeming recoil from steroids. Doctors have been starting patients with too high doses. He starts with 15 mg. of prednisolone.

Dr. Bunim: I must explain the differences in results. Among investigators, there are areas of agreement, but there are also differences. Patients who are admitted to the National Institute of Arthritis and Metabolic Diseases are carefully selected; only refractory and progressive cases are admitted, and high doses of steroids must be used. Stomach x-rays are done every three months. The statistics of steroid therapy include other doctors' patients who may have ulcers. The percentage of improvement also depends upon the economic situation of the patient and on the diagnosis. Some patients improve who do not have rheumatoid arthritis. In England, because of the Health Act, the patient can be hospitalized. In the United States, the patient must have quicker results, hence must have steroids.

Dr. Gil: In Mexico, patients don't have facilities for prolonged conservative treatment. Must be rehabilitated more quickly. Rheumatoid arthritis with visceral involvement demands use of steroids.

Hormone Treatment of Rheumatic Fever

Dr. Lockie: We must give early full doses of steroids.

Dr. Bunim: Investigators get lost in academic debate in evaluating murmurs. Is damage greater at the end of one year in patients treated with steroids or aspirin? The impression that there is no difference between steroids and aspirin is erroneous. If patient on aspirin develops acute congestive failure, he is taken off aspirin and put on steroids. What is there to be lost, if we put a child with rheumatic fever on steroids for a short time (three to four months) as well as on aspirin? If steroids are discontinued, in one-half the cases there will be a rebound. But one can give more salicylates when steroids are discontinued.

Local Therapy with Steroids in Osteoarthritis

Dr. Mata: We must use supportive treatment in addition to steroid therapy. Prednisolone acetate will give a less severe local reaction than other steroids.

†Ralph Dorfman is Director of Laboratory, Worcester Foundation, Massachusetts.

Steroid Therapy in Other Rheumatic Diseases

Dr. Bunim: We must treat lupus erythematosus with huge doses of steroids. Even if the patients reach state of uremia, they will still recover with steroids. Polyarteritis nodosa should not be diagnosed as negative on the basis of one slide alone. Fifty sections should be made, to rule out this condition.

Clinical Picture of Rheumatoid Arthritis

By Dr. Richard Freyberg.

The clinical picture of rheumatoid arthritis is quite familiar to the general practitioner, and will not be repeated here. We shall content ourselves with a comprehensive definition of this condition, as follows: "Rheumatoid arthritis is a chronic, diffuse connective tissue disease of unknown etiology, beginning with synovitis, going on to proliferation and destruction of cartilage and bone, causing deformity and crippling, with a variety of onset and course, both unpredictable, usually with partial remission and relapse."

Immunology and Diagnosis of Rheumatoid Arthritis

By Dr. Joseph Bunim.

The diagnostic criteria of the American Rheumatism Association for rheumatoid arthritis are: (1) morning stiffness, (2) pain on motion or tenderness in one or more joints, (3) swelling in one joint for six weeks, (4) swelling in two joints for three months, (5) swelling, symmetrical, in bilateral joints, (6) subcutaneous nodules, (7) x-ray changes, (8) serologic test for rheumatoid factor, (9) poor mucin clot in synovial fluid, (10) synovial biopsy consistent with rheumatoid arthritis, (11) biopsy of subcutaneous nodule.

A patient has classical rheumatoid arthritis, if he has seven of the above criteria; definite rheumatoid arthritis, if he has five; probable, three; and possible rheumatoid arthritis, if he has two of the above criteria.

Early X-Ray Changes.—Included in early x-ray changes are: osteoporosis (a) spotty (acute), (b) thinned cortex (chronic), (c) coarse trabeculations (intermittent); periostitis (a) inflammatory, with edema, (b) chronic tenosynovitis; erosions (a) surface, (b) pocketed; and narrowed joint spaces.

Mechanism of Agglutination.—Bentonate flocculation test is the most common serologic test for rheumatoid arthritis.

1. It is useful in differential diagnosis. It confirms the diagnosis of rheumatoid arthritis.

2. It is negative in early rheumatoid arthritis.

3. It is intermittently positive.

4. It is independent of host response or treatment.

5. The titer parallels the full expression of the disease.

6. It has a relationship to the prognosis.

There is a positive rheumatoid factor in 80 to 85 per cent of the serologic test.

Complications of Rheumatoid Arthritis.—In patients with high titers in serologic tests, complications include: vasculitis, neuropathy, Felty's syndrome, ischemic skin lesions, and nodules.

General Management of Rheumatoid Arthritic Patients

By Dr. Joseph Hollander.

The cause of rheumatoid arthritis is still unknown; the treatment, empirical. The formula requires constants still unavailable to us. We must start with conservative measures. To this, special drugs are added. Orient patient to aggravating factors and eventual course of the disease. In the average case of rheumatoid arthritis, rest is important. The general rules in the management of rheumatoid arthritis are:

Don't promise cure or quick results.

Be as optimistic as possible.

Rest.—Emphasize emotional rest. Ten to twelve hours' physical rest daily, with afternoon rest periods. Duration of bed rest will vary with severity of the disease. Interspace rest periods with moderate activity. Frequent daily exercise periods to the point of maximum range of motion. Keep within exercise tolerance. Encourage work, if non-traumatizing to joints involved. Night pain may be relieved by analgesics or adequate exercises, casts, traction, corrective surgery.

Physiotherapy.—Physiotherapy includes: optimum bed posture, "demands of daily living" inventory, physical measures for bed patients, and measures for semi-ambulant patients.

Drugs.—Salicylates, aspirin, choline salicylate solution, darvon, rarely codeine, phenobarbital, meprobamate, iron for anemia, transfusion.

Nutritional Diet.—

Results of long-term conservative treatment: improved, fifty-three (60 per cent); stationary, thirteen (25 per cent); worse, thirty-four (15 per cent).

If the patient is severely decompensated, we may resort to crutch—steroids. If not, use gold, antimalarial (chloraquin), butazolidin. Chloraquin has proved disappointing—it is not much better than aspirin. Butazolidin is used less, because percentage of toxicity is higher than any other agent, including steroids. In gout, the incidence of toxicity with butazolidin is less.

The local use of steroids may be added. "Use oil locally where it squeaks, rather than gum up the works with oil generally, hoping it will reach the spot."

Conclusion.—"We have no cure, but much to offer the patient to relieve pain and prevent deformities. We cannot add years to life, but life to years."

Degenerative Joint Diseases—Clinical Picture

By Dr. Richard Freyberg.

There is little glamor to it. More people past forty-five have degenerative joint disease than any other. It is not primarily an inflammatory process. Most often, it is not a systemic disease. It has a local distribution of one or few joints. There is no thickening of the capsule. It is primarily a degeneration of the cartilage—at the weight-bearing portion of the joint, which is the central portion. Cartilage becomes dehydrated, clefts and fissures develop in the cartilage, the weight-bearing surface becomes rough and uneven. The cartilage becomes more and more degenerated. It is wearing out and wearing thin. Spurs develop and irritate the capsule. It is a relatively mild synovitis. There is no osteoporosis. The bone becomes calcified.

It affects chiefly people beyond forty-five. Affected are the weight-bearing joints—the knees, hips, spine. The one exception is the terminal joints of the fingers. In people doing heavy lifting, the joints are more traumatized. It comes earlier in people who are overweight, in joints that have been damaged earlier in life. Lastly, when there has been an infectious process in the joint, such as gonorrhea or a streptococcus infection. Faulty body mechanism increases stress to the joint. The patient is generally very healthy, except in one or two joints. There is an inherited structural difference when degenerative arthritis occurs in young people. Pain comes from stress on soft tissues surrounding the joint.

Degeneration of disc may lead to osteoarthritis or bony changes. In the celebrated case of the 167-year-old man from Peru, there were relatively little changes in the bony structures.

Sudden pain in the joint is not due to osteoarthritis. It is due to a break in the disc, or a breakthrough in osteoporosis, or malignancy.

Treatment of Degenerative Joint Disease

By Dr. Joseph Hollander.

First of all, reassurance is necessary. No one becomes disabled as a result of osteoarthritis. Age alone is not as important as wear and tear. Heredity is a predisposing factor, as are hormonal imbalance (menopause) and male climacteric. Most important is the wear and tear to which the joint has been subjected.

The treatment consists of: (a) prevention and correction of strain, (b) relief of pain, and (c) reassurance.

Correct overweight, adopt and maintain proper posture, engage in postural exercises and training. Correction of mechanical strain involves the correction of flat feet, bow legs. Use arch pads, foot pads. There may have to be a change in physical activity of the patient. Long inactivity worsens joint. Premarin, oral androgen may have to be given.

Relief of pain—Aspirin, 10 grains, four times a day, rarely codeine. No steroids, except locally—prednisolone acetate, hydrocortisone acetate. Use heat judiciously. X-ray treatment has no lasting benefit. Cervical traction is often helpful, as is Sayer sling traction. Thomas collar is frequently used. Back-supporting corsets are important. Massage, liniment are helpful. Crutches may be necessary, elastic bandages, lifting of weights suspended from the knees, exercises with the toes. Surgical intervention is a last resort and is rare. Arthroplasty for severe and lasting pain. There may be long periods of rehabilitation. Loose bodies must be removed. Laminectomy may be needed for pressure of spurs. We cannot cure, but we can ease the condition.

The Clinical Picture of Gout

By Dr. Javier Rovler Gil.

Four hundred patients were studied: one group of poor patients, the other, office patients. Sex: female, 4.2 per cent; male, 95.8 per cent. Age during first attack—forty to fifty years. Patients at a higher socio-economic level have their first attack at an earlier age. Obesity is found more frequently in the lower status.

Race: Mexican, 92 per cent. Of these, white patients constitute 62 per cent, mestizo 23 per cent, Indian 7 per cent, foreigners 8 per cent.

Type of articular involvement: Metatarsophalangeal, only 25.4 per cent, polyarthritis 32.3 per cent, monoarticular (other than the big toe) 42.3 per cent.

Frequency of joint involvement: Big toe, 31 per cent; tarsal, 14 per cent; ankle, 19 per cent; knee, 18.9 per cent; wrist, 7.9 per cent. Each attack is more progressive.

Complications: Nephrolithiasis, 42 patients (10.5 per cent); nephropathy, twenty-five patients (6.2 per cent); chronic arthropathy, twenty-eight patients (7 per cent). Urinary sediment: normal, 38.8 per cent; moderate, 13.2 per cent, hematuria, 58 per cent.

Treatment of Gout

By Dr. Maxwell Lockie.

In this disease, proper treatment can do most good. The patient must cooperate to ward off future attacks. It is a disease of abnormal uric acid metabolism.

1. *Rest*—Gouty patients are drivers, pushers.

2. *Body Weight*—One can precipitate gout by high fat diet. Reduce weight gradually.

3. *Diet*—Eliminate liquor. Low fat.

4. *Medication*—

(a) Colchicine in 0.5 mg. tablets. Two tablets every two hours until nausea or loose bowels, then stop. Paregoric for diarrhea. Complete recovery in twenty-four to thirty-six hours.

(b) Colchicine intravenously, 2 to 3 mg. b.i.d. for one day. For emergency only.

(c) ACTH intramuscularly—40 to 100 units. One injection may abort attack. May repeat daily. May give ACTH intravenously, 20 units over an eight-hour period (in hospital), every day, if necessary, for three to four days. Along with ACTH, give colchicine two tablets daily for two weeks.

(d) Butazolidin—200 mg. every two hours for four doses. May repeat the following day, if necessary. There are no side-effects.

(e) Triamcinolone — (Aristocort) — 8 mg. every two hours for four doses—will stop acute attack. Add small doses of colchicine—one tablet two to three times a day.

To Prevent Recurrence.—

1. Mild case (less than once a year), where there are no tophi and where there is less than 7.5 mg. per cent serum urate. No wine, beer, vermouth or champagne; rest and reduction in weight. No other medication needed.

2. Moderate case (more than one attack a year), where there are no tophi, but the serum urate is more than 7.5 mg. per cent. Colchicine, 0.5 mg. b.i.d. for life.

3. Severe case (more than one attack a year), where the urate level is more than 7.5 mg. per cent and where there may be tophi. Colchicine daily, two tablets b.i.d.; Benemid 0.5 gm. b.i.d. Excretes uric acid from system, decreases size of tophi. Some tophi may disappear entirely. If benemid does not work (does not lower the uric acid level), give anturan or flexin. Use colchicine along with anturan or flexin. Diet—low fat, adequate protein, eliminate liver, kidney, sweetbreads, anchovies. Eliminate liquor. Surgery may be necessary for the thorough elimination of easily accessible tophi. The future for patients with gouty arthritis is very hopeful.

Cardiovascular Surgery for Rheumatic Fever Patients

By Dr. Genaro Pliego, Department of Surgery, National Institute of Cardiology, Mexico.

Cardiovascular surgery for rheumatic valvulitis—mitral stenosis. Must select patients for surgery.

Mitral Commissurotomy (915 cases):

Pure mitral stenosis	673 cases	(73.55%)
Double mitral lesion	242 cases	(26.45%)

Associated Valvular Lesions

Tricuspid lesion	280 cases	(36.01%)
Aortic lesions	40 cases	(4.3 %)

Preoperative Conditions

Cardiac insufficiency	129 cases	(14.09%)
Auricular fibrillation	170 cases	(19.67%)
Previous embolism	73 cases	(7.97%)
Cardiomegaly	159 cases	(16.28%)

Operative Findings

Thrombosis	121 cases	(13.22%)
In auricular appendage	66 cases	(7.21%)
Left auricle	15 cases	(1.64%)
Left auricle and auricular appendage	40 cases	(4.37%)
In pure mitral stenosis	82 cases	(12.18%)
Double mitral stenosis	26 cases	(10.74%)
Auricular fibrillation	72 cases	(41.17%)
With calcification	27 cases	(14.56%)
With previous embolism	22 cases	(30.13%)
Valvular calcification	191 cases	(21.74%)
Pure mitral stenosis	119 cases	(17.68%)
Double mitral lesion	80 cases	(33.06%)
Auricular fibrillation	32 cases	(18.82%)
With previous embolism	18 cases	(24.65%)
Subvalvular stenosis	181 cases	(19.78%)
Pure mitral stenosis	684 cases	(74.75%)
Double mitral stenosis	227 cases	(24.81%)
Normal valve	4 cases	(0.44%)

Type of Commissurotomy

Digital	665 cases	(72.67%)
Beck Maneuver	133 cases	(14.54%)
Instrumental	84 cases	(9.18%)
Without Commissurotomy	33 cases	(3.61%)

Exploratory Cardiotomy and Thoracotomy

Due to thrombosis	9 cases	(7.43%)
Due to calcification	7 cases	(3.57%)
Due to mitral insufficiency	13 cases	(5.37%)
Normal valve	4 cases	(0.43%)

Operative Complications

Auricular laceration	23 cases
Wound of left ventricle	2 cases
Cardiac arrest	7 cases
Cerebral embolism	18 cases
Peripheral embolism	4 cases
Pulmonary edema	1 case

Postoperative Complications

Rheumatic activity	150 cases
Auricular fibrillation	112 cases
Cardiac insufficiency	63 cases
Cerebral embolism	27 cases
Peripheral embolism	14 cases
Pulmonary edema	9 cases
Hemoptysis	14 cases
Pulmonary infarct	14 cases

Mortality

Number of deaths	35 cases
In operating room	6 cases
Immediate post-operative	29 cases
In pure mitral stenosis	23 cases
In double mitral stenosis	12 cases

Results

Excellent	444 cases
Good	362 cases
No improvement	41 cases
Without commissurotomy	29 cases
Normal valve	4 cases
Deaths	35 cases
Total	915 cases

From the above it may be seen that 806 out of 915, or 88 per cent, of the commissurotomy patients had either excellent or good results.

New Corticosteroids

By Dr. Gil.

Since the advent of cortisone, there have been seven modifications that increased the anti-inflammatory activities of the steroids, while there has been no diminution in their side-effects. Following cortisone, there came hydrocortisone, prednisone, prednisolone, methyl prednisolone, triamcinolone and dexamethasone. The biochemical and therapeutic properties of four new corticosteroids are now under investigation. All of these new products have marked side-effects. Following are the incidence of the most important secondary effects: Headache, 55 per cent; dizziness, 40 per cent; weight gain, 45 per cent; increase in blood pressure, 5 per cent; ecchymosis, 10 per cent; gastric hyperacidity, 10 per cent; general well being, 80 per cent; cushinoid, 20 per cent.

Summary.—The four new corticosteroids show from one to four times more anti-inflammatory activity than prednisolone. The consideration of the side-effects would not interfere with the use of steroids, if treating severely affected patients with rheumatoid arthritis.

Some Current Views on the Use of Steroids in Arthritic Diseases

By Dr. N. Oliver Rothermich, Clinical Professor of Medicine, Ohio State University, Ohio.

A basic program is essential. The local use of steroids can make the systemic therapy with steroids less necessary. Don't use steroids, if not necessary. Get by without them, if possible.

Rheumatoid arthritis is not a disease, but a syndrome. There are several different entities within rheumatoid arthritis. The progression is not the same in different cases of rheumatoid arthritis.

Steroid therapy should be used conservatively and in minimal doses.

Therapy for Rheumatoid Arthritis.—

1. Basic—Rest, salicylates, physiotherapy.
2. Steroid therapy. Desired effects—anti-inflammatory.

Undesired effects

Equivalent doses		*Sodium retention*
Hydrocortisone	20 mg.	4 plus
Prednisone	5 mg.	2 plus
Methyl prednisolone	4 mg.	1 plus
Triamcinolone	4 mg.	0
Dexamethasone	4 mg.	0

Reaction to Steroid Therapy—No patient should be started on maximum dose and then reduced. He should be started on the minimum dose and then increased. The side-effects are due to the use of maximum doses. Not more than 3 to 4 units should be given at one time. Serious ill effects do not occur on low dosage. Steroids are in ill repute. Therefore, we try to find scapegoats. Gold therapy in rheumatoid arthritis is enormously beneficial in a high percentage of cases. If the patient is in a poor socio-economic state, we must give him all we have, including steroids. Whoever is threatened with ankylosis and joint destruction must have steroids. Steroids make a big difference in how rapidly the patient gets bone destruction. Mild side-effects (moon-face, hirsutism) are really no contraindication to steroid therapy. Psychosis—two in ten years—may be treated with shock therapy while steroids are continued. Duodenal ulcer—contentions are strong, but evidence is weak. Steroids are definitely accepted as non-ulcerogenic therapy. They may produce gastric, not duodenal ulcer. "The lighting up of T.B." is correct if high doses are used. It does not occur if the patient receives a low maintenance dose and if there was no tuberculosis activity before steroids were started. Osteoporosis and fractures are a serious potential threat, but a problem only in elderly, post-menopausal and rheumatoid arthritic patients who already have osteoporosis. Even in this group, fracture is preventable if the patient is on a low maintenance dose, if he receives gonadal hormone therapy, and if he is on a high protein diet.

Private patients with rheumatoid arthritis currently on active treatment: Dexamethasone 2 mg. daily (not more than 4 mg.). It is stopped if there is an adverse fluid retention reaction and a weight gain. Dexamethasone has a tremendous effect on the appetite.

Panel Discussion

New Corticosteroids

Dr. Freyberg: Experience with new steroid compounds—15 patients, 5 months: Preparations of Dr. Gil have definite advantages: less gastric irritation, no hypertrichosis, no potassium deficiency, no edema, smooth anti-rheumatic control. Early indications favorable.

Dr. Lockie: For rheumatoid arthritis, one must use a broad program. Gold first; if no response, steroids. Twenty-two patients on Dr. Gil's compound, 5 months. Favorably impressed. Will make report in the near future. Decreased ecchymosis.

Dr. Freyberg: Also noticed diminished ecchymosis.

Dr. Hollander: In treating seven or eight patients, the effects were questionable.

Dr. Katona: In thirty patients whom I saw for one and one-half years, I began treatment with 1 to 2.5 mg., then 10 to 12 mg. for suppression. Anti-rheumatic activity was three to three and one-half times that of prednisone, and more than dexamethasone. Side effects were transitory dizziness, some burning sensation in the stomach. No changes in blood pressure were evident. There was a sensation of well-being. There was an occasional Cushing syndrome. Ecchymosis in two patients was mild and transitory. This treatment was more effective and better tolerated than others. It is of great importance for the future.

Dr. E. Alper: All steroid products produce hormonal effects. All produce lymphocytosis, which give good results. Hormonal effects can be predicted.

Dr. Hollander: The term "side effects" is merely a matter of semantics. Should use term "hormonal effects."

Dr. Dorfman: Dr. Alper is correct. Aldosterone is one-third as effective as hydrocortisone. Is highly specific in effect on sodium and potassium. May get substance that has specific anti-inflammatory effects. Nathan Kaplan, of Brandeis University, has shown specific effects of enzyme lactic acid on liver, kidneys, spleen, muscles. There is a tissue specificity in respect to enzymes. Glycogen deposition and protein metabolism: if we can get separation, the future looks good.

Dr. Rothermich: The clinician will be better off if he will regard the newer drugs as pharmacological, rather than hormonal, substances.

Dr. Dorfman: New steroids depend upon certain position of the molecules, to which we add or subtract. There is little difference between effects on human and rat. The general scheme is the same, yet there is some difference, because of tissue specificity inherent in genes. Chemists supply biochemists with many compounds, which are being investigated at this time.

Dr. Freyberg: We cannot take patient off steroids. Every time a physician puts a patient on steroids, he makes a possible life-time contract with the patient to keep him on steroids. Continued therapy with the same dose will have less and less effect.

Dr. Alper: Cortisone is not as effective in joint or skin as hydrocortisone.

Dr. Dorfman: We are dealing with enzymes which differentiate between local and systemic effects of steroids.

Dr. Freyberg: We should know the entire patient, before we start treating a patient with steroids. Steroids should be used, not abused, just as digitalis, which is often abused. The steroids fail to be the last goal we are looking for.

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The Need for Early Treatment Of the Rheumatoid Hand

Alfred B. Swanson, M.D.
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FROM a therapeutic standpoint "arthritic hands" are often seriously neglected. The general attitude is that, with this severe disease, crippling of the fingers is to be expected. The deformed hand should not be accepted as an eventual manifestation of arthritis. It is, rather, a hand deformed from neglect of the complications of the disease.

The basic pathology of the arthritic lesion in the hand is the same as elsewhere in the musculoskeletal system. In the hand, however, the hypertrophic synovitis that occurs in joints also occurs in the tendon sheaths and in bursae. The deformities are most often secondary to tendon ruptures, rheumatic tenosynovitis with binding down of the tendons, dislocation of the extensor tendons off the knuckles and contracture of the intrinsic musculature. Loss of the normal balance of the fingers occurs. Once the imbalance has been established, there is an increasing tendency to deformity. Hypertrophic synovitis causes further subluxation of the finger and wrist joints. The function of the hand for grasp, release, pinch, strike and hook are affected and may be completely lost. The loss of usefulness of the hand may make the patient totally dependent on others for his livelihood, and interfere with the performance of his normal daily activities.

Often the earliest manifestations of rheumatoid arthritis in the hands is spasm of the intrinsic muscles.[1] This is evidenced by inability to flex the interphalangeal joints with the metacarpal phalangeal joints extended. The metacarpophalangeal (MP) joints are usually more frequently involved in the disease process than the interphalangeal (IP) joints. There is usually the development of ulnar deviation of the fingers at the MP joints. In the normal hand, flexion and extension of the fingers is accompanied with some ulnar deviation tendency. In the normal resting posture of the hand, and especially the painful hand, the fingers are allowed to drop into ulnar deviation. With associated synovitis of the MP joints and intrinsic muscle spasm, this deformity becomes a vicious circle of imbalance. If the ulnar drift is resisted early in the stages of the disease, this deformity may be prevented. In fact, it is possible to produce a radial drift at the MP joints if the fingers are held in this position.

The wrist joint may also be involved. Palmar subluxation, flexion contracture and dorsal subluxation of the ulna may be present. The hypertrophic synovium that occurs in these joints creeps over the articular cartilage and interferes with its normal nutrition. Cartilage destruction may then ensue. The capsular structures are also loosened and stretched by the invading, swollen granulation tissue. Joints may, thus, more easily subluxate or dislocate. Tendons and tendon attachments may also be involved by the invasive synovia. This is especially true of the extensor tendons. They may become attenuated and rupture with minimal trauma. Hypertrophic bone edges, especially at the wrist, may grind away moving tendons and cause them to rupture.

Medical measures should be continued only in the acute stages and should include salicylates, phenylbutazone and steroids for their anti-inflammatory effect. Steroids, alone, will not prevent deformities and it is felt by some that the deformities are more frequent with the chronic use of these drugs.[2] Intraarticular injections of one of the hydrocortisone products may be of benefit in joints where a boggy, hypertrophied synovitis is present. The local use of steroids is to be preferred if the joint process can be localized.

Every arthritic patient should have a physical and occupational therapy regime directed to avoid de-



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formities of the hand. A home program of treatment should preferrably be carried out. Each patient should be his own therapist. A high level of physical activity should be insisted upon. Normal living should be encouraged. Therapy should be simple and not too time-consuming. Heat is used for its muscle relaxing, vasodilating and analgesic effect. Heat is best obtained by whirlpool or paraffin baths. In the home situation, running hot water from a faucet into a partly filled sink or pan may be used instead of the whirlpool. Paraffin baths are also relatively simply done at home. Four cartons of paraffin and one, 10-ounce bottle of baby oil are placed together in a large pan and heated slowly to the melting point (approximately 115°). The hand is dipped quickly to 2 inches beyond the wrist, repeating twelve times. The paraffin is then allowed to dry on the hand. The hand is wrapped in a heavy towel for fifteen minutes to maintain the heat. (The paraffin is removed by stripping from the skin, holding the hand over the pan so that the paraffin may be used over again). Exercises of the fingers may then be more easily accomplished. Diathermy or ultra-sound are not recommended as a source of

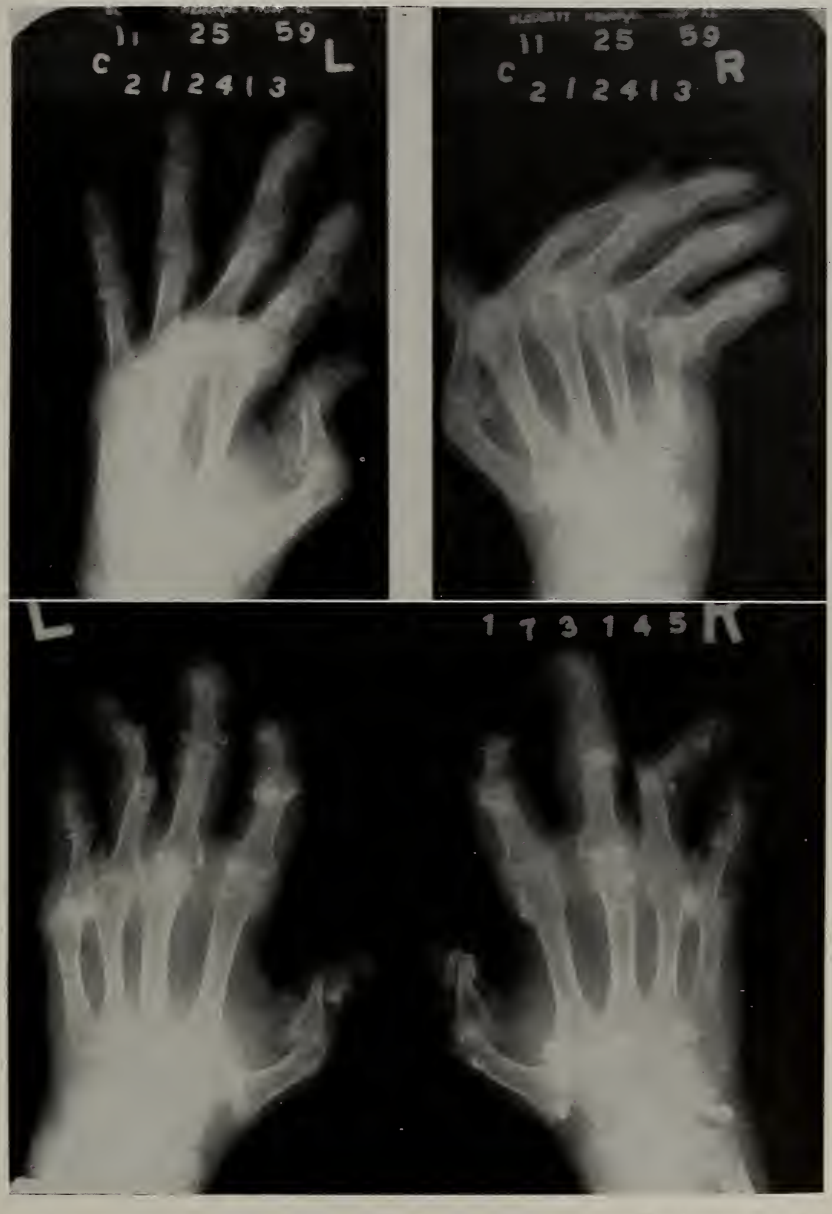


Fig. 1. *(above)* Typical neglected "rheumatoid hands." Note the ulnar deviation at the MP joints with subluxation and flexion deformity. The thumb shows flexion deformity of the MP and hyperextension of the IP joint.

Fig. 2. *(below)* Destructive rheumatoid arthritic hand. Note the loss of bone and joint substance and some calcific deposits.

heat because of their possible destructive effects on attenuated tendons.

Passive stretching of fingers is to be avoided. Massage is usually of little benefit. Active exercises, frequently done throughout the day, are of the most benefit. Exercises should be designed to maintain joint motion and prevent deformity. They should include flexing the IP joints and extending the MP joints and wrist. Radially deviating the fingers, especially the 2nd finger to exercise the 1st dorsal interosseous muscle, is of benefit in preventing ulnar drift. Exercises are more easily done during the application of heat or immediately afterward. Occupational therapy exercises for active, productive motion of the hand are indicated where facilities are available.

Occasionally, dynamic bracing to stretch out deformities should be used. However, night bracing with the hand in the functional position is usually adequate. Bracing should be designed to maintain interphalangeal joint flexion and metacarpal phalangeal joint extension. Ulnar deviation and flexion deformity of the MP joints and flexion deformity of the wrist should be prevented.

Surgery

Surgery of the rheumatoid hand should be done as soon as indicated to prevent fixed deformities. Persistent hypertrophic synovia should be removed very early in the disease process before its destructive effect on joints and tendons has occurred. Tendons should be repaired when ruptured no matter what the stage of the disease. Occasionally tendon transfers may be utilized in place of direct suture of the tendons when the tendon substance is inadequate. Athroplasty and arthrodesis should wait until the burned-out stage of the disease is reached. Rheumatoid compound ganglions should be removed if they do not disappear with conservative treatment. Rheumatoid nodules may disappear, but if they mechanically interfere with function or are permanently sore, they should be removed.

Surgical Treatment of Specific Deformities

Mallet Finger.—This common deformity is due to attenuation and rupture of the extensor slip attachment to the distal phalanx. The distal IP joint goes into flexion deformity. Secondary hyperextension deformity of the proximal IP (PIP) joint may occur if the deformity is prolonged. This is due to a tendon imbalance in favor of the extensors, both intrinsic and extrinsic, at the dorsum of the PIP joint. Very early repair of the tendon insertion distally should be done. Later, a fusion of the distal IP (DIP) joint with intramedullary or cross-wire fixation may be necessary. The hyperextensible PIP joint may be treated by tenodesis[5] of the sublimis tendon to the proximal phalanx. This reinforces the stretched out palmar structures. A flexed position of 30° to 40° of this joint should be maintained.

Boutonniere Deformity.—This deformity is due to the rupture of the central slip of the long extensor to the middle phalanx. The triangular ligament holding the lateral bands together also ruptures. The lateral bands then subluxate volarward around the joint. A deformity of flexion of the PIP joint and extension of the DIP joint occurs. This deformity is extremely resistant to treatment in its late stages. Early in the process, repair of the ruptured tendon and triangular ligament may be done. Later, sectioning of the lateral bands at the PIP joint may be of some benefit. In the late stages, a fusion of the PIP and DIP joint in functional position is preferred.

Thumb Deformities.—Thumb deformities usually consist of adduction deformity of the thumb, flexion deformity of the MP joint and hyperextension deformity of the distal joint. Occasionally, subluxation and dislocation of these joints may occur. The carpal metacarpal joint is usually not involved. Fusion of the IP and MP joints of the thumb still allows for function as long as the carpal metacarpal joint is intact. Release of the adductor contracture, where present, will improve thumb function.

MP Joint Deformities.—Metacarpal phalangeal joints are usually deformed in flexion and ulnar deviation. This deformity, once established, is secondarily aggravated by the altered mechanical forces from deformed distal joints, ulnar displaced extensor tendons off the knuckles and palmar subluxation of the proximal phalanx on the metacarpals. Early removal of the hypertrophied synovia will prevent subluxation of the extensor tendons off the knuckles as well as subluxation of the MP joints.[4] Surgical relocation of the dislocated extensors will be necessary to prevent further deformity. In severe cases, an arthroplasty at the MP joint in conjunction with the synovectomy may be necessary. An osteotomy of the necks of the metacarpals in flexion may also re-establish the joint alignment and improve force couple action at the MP joint. This will improve the extensor ability at the MP joint and also improve

the ulnar subluxation tendency. Movement of the MP joints of the second and third fingers are important in pinch and grasp. The fourth and fifth fingers are mainly for hook action and the MP joints may be arthrodesed. Arthrodesis of these joints will also improve the position of the fingers as well as aid in preventing further ulnar deviation of adjacent fingers.

Wrist Deformities.—Palmar subluxation of the wrist with flexion deformity and posterior subluxation of the ulna that cannot be adequately treated by physical measures can be helped by resection of the distal ulna. Occasionally, a fusion of the proximal row of the carpal bones to the distal radius should be done.[3]

Carpal Tunnel Syndrome.—The carpal tunnel syndrome with its associated pressure symptoms on the median nerve may be treated with hydrocortisone injections into the tunnel or by resection of the carpal ligament and release of the nerve.

Tenosynovitis.—Tenosynovitis crepitans is resistant to treatment. If the process is localized and does not respond to injections and physical therapy methods, sectioning of tendon sheaths may be necessary. Snapping tendons or trigger fingers are not usually a part of the rheumatoid arthritic hand. Where they occur, they are best treated by sheath section if one to three hydrocortisone injections do not help.

Other Arthritic Lesions.—Other arthritic lesions involving the hands are not, as a rule, as destructive to function and do not require surgical intervention. Destructive rheumatoid arthritis with marked shortening of the phalanges usually does not require surgery unless the fingers are markedly unstable. In this case, joint fusion may be indicated. Gouty arthritis may be accompanied by painful deposits of urates which may be surgically removed. Psoriatic arthritis is usually associated with involvement of the distal joints and is not usually associated with severe crippling except in the late stages. Osteoarthritis affecting the hand is seldom as disabling as rheumatoid arthritis. Occasionally, a mallet finger may occur and may require surgery. Heberdeen's nodes are usually best treated conservatively, except where they are large and interfere with function.

Summary

A plea is made for the early treatment of the so-called rheumatoid arthritic hand. Emphasis is placed on the importance of specific local treatment whether it involve physical measures or surgery. It is emphasized that surgery in the rheumatoid hand may be of marked benefit in improving function. Arthritic hands are usually seen too late for simple surgery. Early surgical intervention is preferred before severe imbalance of the hand occurs.



Fig. 3. *(above)* Rheumatoid arthritic hands of patient with long-term treatment by steroids. Note mallet fingers, hyperextensible PIP joints and flexion deformities of wrist and the Boutonniere deformity of ring finger of the right hand. The finger deformities are secondary to extensor tendon ruptures.

Fig. 4. *(below)* Mallet fingers treated by fusion of the DIP joints and sublimis tenodesis of the PIP joints. Boutonniere deformity improved moderately by lateral band section.

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Potent Hypotensive Drugs

Comparative Analysis of a Ganglionic Blocking Agent and Two New Sympathetic Inhibitors in Severe Hypertension

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DESPITE our various clinical successes with the rauwolfia's, thiazides and hydralazine as antihypertensive agents, treating the severer forms of hypertension still remains a difficult problem. A malignant hypertension or hypertension with complications (cardiac insufficiency, azotemia, papilledema, and the like) particularly, are often unresponsive to these agents. Although these forms of hypertension have responded to the ganglionic blocking agents of which mecamylamine (Inversine®) is most representative, the severity of side reactions to these agents—constipation, blurring of vision, et cetera — limits their therapeutic usefulness.

Recently (July 1959) reference to two new antihypertensive agents which may replace the ganglionic blockers for the more severe forms of hypertension appeared almost simultaneously in the clinical literature. One of them was bretylium tosylate (Darenthin) and the other was guanethidine (Ismelin).

Boura and associates[1] reported on the first drug and Page and Dustan[2] reported on the second. Apparently both compounds selectively inhibit the transmission of nerve impulses via the peripheral sympathetic nervous system and are sympathetic inhibitors. Both produce significant orthostatic hypotension without the more serious side effects of parasympathetic blockade. However, notable differences have been seen by us and reported by others between these two agents.

Brodie[3] recently noted that all our therapeutic efforts in antihypertensive therapy have been directed towards reducing sympathetic stimuli to the arterial wall usually accomplished by blocking or interfering with sympathetic stimuli at different sites of the sympathetic nervous system. The site of action of the two new agents as compared to some of the other commonly used compounds is demonstrated in Figure 1.

Thus we see that interference with sympathetic stimuli may occur in different places with different drugs. These include the following:

Mode of Action of Some Antihypertensive Drugs.—

1. An action upon the central nervous system is exerted by the well-known sedative and tranquilizing agents.

2. The ganglionic blocking agents (hexamethonium, pentolinium, chlorisondamine, mecamylamine, et cetera) act upon the peripheral autonomic ganglia, competing with acetylcholine, thereby preventing the transfer of the stimulus from the pre-ganglionic fiber to the peripheral ganglion cell. Since this interference takes place in all autonomic ganglia, the parasympathetic system is blocked causing undesired side effects.

3. Reserpine depletes catecholamines at the peripheral nerve endings. A similar central action upon catecholamines is debated.

4. The thiazides probably work through salt depletion. A decrease of the sodium ion would reduce the reactivity of the arterial wall to norepinephrine.[4,5] Decreased thickness of the arterial wall due to disappearance of sodium ion is also considered. Plasma volume is reduced. Finally, a direct antihypertensive action of unknown modus has been postulated.

5. According to Brodie,[3] guanethidine apparently depletes the stores of norepinephrine from the peripheral nerve endings. This may or may not be due to release or blocking of norepinephrine synthesis and remains to be determined. Bretylium on the other hand, neither releases nor blocks norepine-

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Inversine is a product of Merck, Sharp & Dohme; Darenthin, Burroughs Wellcome & Company; Ismelin, Ciba Pharmaceuticals.

phrine synthesis, but does seem to make the stores unavailable.

Reasons for Study and Selection of Patients.—Twenty-three patients (fourteen of whom had been on mecamylamine before) received one or both of the new agents at separate periods ranging from one to six months. The causes of hypertension varied. Sixteen of these patients had hypertension of unknown causes; four had pyelonephritis; three had renal atherosclerotic disease.

All patients had established diastolic hypertension and had failed to gain normotensive levels of pressure on combinations of rauwolfia, thiazide or in some instances hydralazine.

Our criteria for therapeutic usefulness was determined by number of tablets used, convenience of treatment, side effects, as well as achievement of satisfactory hypotensive response.

Methods of Treatment.—Patients were advised to check their blood pressure twice daily, about one hour after arising and again ten to twelve hours later. They had been instructed in home blood pressure recordings during the initiation of treatment with blocking agents in the hospital. They were instructed to omit the blocking agent, if the systolic standing blood pressure was below 120 mm. Hg just before time of dose. This had been established during the patients' hospitalization. This precaution against serious consequences of orthostatic hypotension thus provided individualized dosage of the drug. If the patient was taking basic medications (rauwolfia, thiazides and, in some patients, hydralazine), they were continued at the same dose level.

The majority of patients had been fairly well controlled on mecamylamine. However, our reason for change was specifically to eliminate mecamylamine's undesirable side effects. Changes in blood pressure levels were therefore not expected to be very striking.

Results

Twenty-three patients received either mecamylamin, bretylium tosylate or guanethidine exclusively or in combination at separate periods of time. The results of our study are presented in Table I and II. The tables give information about the age of the patient, the fundoscopic findings (KWB), the serum creatinine, and the dosage used in each patient. The degree of hypertensive retinopathy and the serum-creatinine serve as an index for the amount of vascular involvement. All patients except Case 14 had left ventricular hypertrophy by electrocardiogram and cardiac enlargement by chest x-ray. Blood pressure levels are given in sitting and standing position and represent average values of home readings taken twice daily over periods of for one or more months. Nine patients received mecamylamine originally and were given bretylium tosylate subsequently (Cases 1-9). After six months of therapy only Case 8 is still on bretylium tosylate. The patient in Case 9 developed tolerance to this drug and was switched back to mecamylamine upon his own request. The other seven patients were not well controlled on bretylium tosylate. They developed tolerance (Cases 1, 2, 5), or marked fluctuation of blood pressure (Cases 3 and 6) or annoying side effects (Cases 4 and 7—nasal stuffiness).

In two patients (Cases 22 and 23) bretylium was used as the first blocking agent. These patients have been followed for five to six months and are still on this drug. Patient number 23 shows very good control, while Number 22 seems to be developing tolerance.

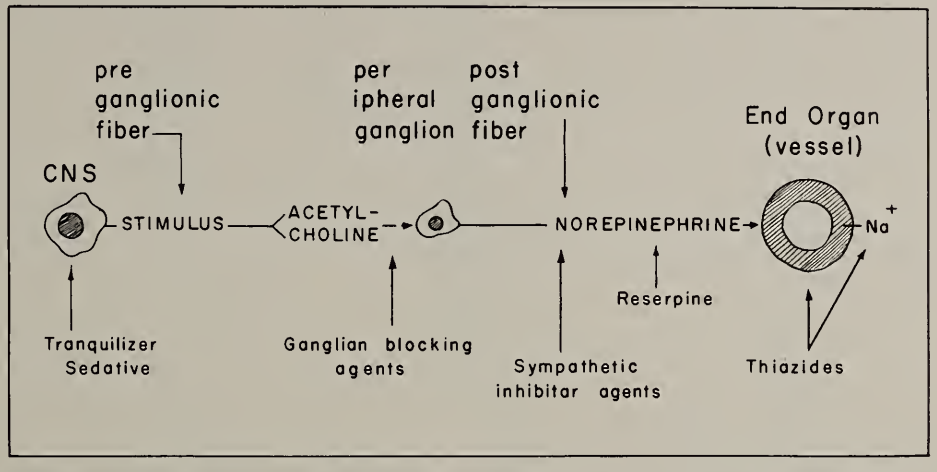


Fig. 1. Mode of action of some antihypertensive drugs on sympathetic nerve impulse and vessel wall.

TABLE I. SUMMARY OF COMPARATIVE ANALYSES USING POTENT HYPOTENSIVE DRUGS
14 Patients

No.	Name	Optic Fundus (KWB)	Serum Creatinine (mg. %)	Mecamylamine (mg. per day)	Blood Pressure Sitting (Standing)	Bretylium Tosylate (mg. per day)	Blood Pressure Sitting (Standing)	Guanethidine (mg. per day)	Blood Pressure Sitting (Standing)
1.	J.B. 46	IV	1.7	15	155-98 (138-92)	1.200	170-103 (148-97)	50	163-100 (138-91)
2.	S.D. 50	II	1.7	20	170-116 (147-109)	2.400	190-110 (177-105)	225	169-106 (157-101)
3.	H.S. 49	II	1.1	20	170-94	400	175-93	50	160-85
4.	R.S. 50	II	0.6	5	179-103 (165-103)	200	161-97 (148-94)	20	147-89 (128-79)
5.	B.W. 51	II	1.5	7.5	189-115 (177-105)	1.200	188-118 (174-108)	100	183-114 (157-103)
6.	R.Y. 41	I	0.9	1-15	177-96 (148-96)	200	191-100 (154-105)	20	186-104 (139-95)
7.	R.M. 48	II	1.0	10	140-90 (130-80)	400	163-88 (154-82)	20	173-85 (167-80)
8.	C.M. 60	II	1.0	7.5	166-96 (156-87)	1.600	166-100 (158-93)		
9.	W.L. 33	III	3.0	37.5	157-105 (124-83)	2.000	176-111 (141-94)	Changed to mecamylamine	
10.	F.C. 52	II	1.3	5	132-97 (130-95)			20	132-99 (125-90)
11.	R.L. 61	II	0.5	40	172-120 (138-102)			30 +2.5 Meca.	159-100 (110-73)
12.	S.M. 55	II	0.8	10	162-94 (152-88)			50	170-91 (158-84)
13.	H.S. 60	II	2.3	10	178-124			37.5	156-100 (140-96)
14.	C.T. 31	0	0.8	7.5	136-97 (135-96)			75	134-92 (132-90)

The average sitting blood pressure of the first group of patients (Cases 1-9) on bretylium tosylate was 164/102 mm. Hg, while the average pressures for the same group of patients on mecamylamine were 167/101. Thus indicating no significant drug difference. The average standing pressures in the same group were 157/97 for bretylium tosylate and 148/94 for mecamylamine. Again the difference is not striking, though mecamylamine seems to be more effective. However, as others have noted, patients on bretylium tosylate have often developed tolerance, fluctuation, or side effects.[6,7,8]

Seven patients were therefore changed to guanethidine. After periods ranging from one to three months, all seven have shown lower diastolic blood pressures in the standing position than on either mecamylamine or bretylium tosylate. Case 7 had the same diastolic pressure in the standing position on both mecamylamine and guanethidine.

Five other patients (Cases 10-14) were switched from mecamylamine to guanethidine. After periods of one and one-half to three months on the latter drug, their average diastolic standing blood pressure was lower than before.

Seven patients had guanethidine exclusively as their first blocking agent (Cases 15-21). These patients are very well controlled. Case 17 may probably need a higher dosage.

Profound reduction in systolic standing blood pressure especially on arising in the morning was a frequent finding. Orthostatic hypotension in some instances caused faintness and in one case, a blackout.

Comparing over-all average blood pressures on mecamylamine as compared to guanethidine the following figures: 161/97 for guanethidine and 163/104 for mecamylamine in the sitting position; 141/89 for guanethidine and 132/97 for mecamylamine in the standing position demonstrate guanethidine is more effective in reducing the diastolic pressure than mecamylamine.

We would like to mention two additional patients not included in this study. Both individuals had severe systemic disease. One patient suffered from disseminated lupus erythematosus, associated with severe hypertension and cardiac insufficiency, while under steroid therapy. Blood pressure was resistant to mecamylamine and bretylium tosylate, but guanethidine proved effective at fairly large dosages.

The second patient had diffuse vasculitis and glomerulitis with severe hypertension. This patient had also received steroid therapy. The hypertension responded poorly to all the usual drugs, but here again guanethidine caused a prompt lowering of blood pressure. Prolonged treatment had to be abandoned because both patients developed a rising blood urea nitrogen. Nevertheless, the fact that we were able to control the hypertension somewhat with guanethidine is worthy of mention, we believe. Further study is indicated since we have had considerable difficulties with blood pressure control in similar cases of systemic disease.

Side Effects.—Table III shows side effects observed on mecamylamine, bretylium tosylate and guanethidine. It clearly indicates the superiority of guanethi-

dine and bretylium tosylate over mecamylamine with reference to intolerable side effects.

Mecamylamine is known for its effect upon the parasympathetic ganglia which eventually leads to rather severe constipation. All of our patients on mecamylamine suffered from constipation. The administration of prostigmine proved useful in some but not in all cases. Other effects of parasympathetic blockade were dryness of mouth (five cases), blurring of vision (five cases) and impotence (four cases). The side effects of this drug frequently created intolerable situations which often prevented us from administering full therapeutic dose.

In contrast, bretylium tosylate and guanethidine showed markedly fewer side effects—apparently because they do not influence the parasympathetic ganglia. Sympathetic blockade, however, may produce uninhibited action of the parasympathetic system. Accordingly, diarrhea has been noted in patients taking bretylium tosylate and guanethidine. Impotentia erigendi caused by mecamylamine was not evident after patients switched to the sympathetic inhibitors, although lack of ejaculation occurred in eleven of our patients on the latter drugs. Facial pain due to bretylium tosylate, as observed by other authors, did not occur in any of our patients.[8]

An unique side effect noted on bretylium tosylate was nasal stuffiness which was present in only two cases—in contrast to a great many patients in the series reported by Boura. However, this may reflect the smaller dosage level or perhaps the concurrent use of chlorothiazide in most of our patients which may have offset the nasal congestion. This is pure speculation on our part.

Guanethidine was remarkably free from any significant side effects, although ten men had complete inhibition of ejaculation and one woman reported inability to experience a sexual climax. Diarrhea occurred in eight patients. In some of these patients, the combined use of guanethidine and mecamylamine resulted in less diarrhea with maintained normotension. Abdominal pain and diarrhea occurred in two patients on guanethidine (not shown in Table III). This was relieved by the combined use of guanethidine and mecamylamine.

TABLE II. SUMMARY OF COMPARATIVE ANALYSES USING POTENT HYPOTENSIVE DRUGS

Nine Patients

No.	Name	Optic Fundus (KWB)	Serum Creatinine (mg. %)	Pre-Treatment Blood Pressure Sitting (Standing)	Dosage (mg. Per Day)	Blood Pressure Sitting (Standing)
On Guanethidine						
15.	K.H. 42	III	1.3	169-110 (161-105)	25	148-96 (137-95)
16.	M.T. 50	II	0.6	160-109 (164-110)	25	158-95 (156-92)
17.	L.M. 41	I	1.7	178-123 (146-113)	20	145-120 (133-107)
18.	B.R. 44	I	1.3	202-119	25	152-90 (128-83)
19.	W.M. 67	IV	1.7	177-87 (176-89)	37.5	157-83 (127-72)
20.	M.L. 55	III	0.5	206-115	10	151-96 (137-91)
21.	F.H. 51	II	0.5	159-95 (157-94)	20	147-92 (137-89)
On Bretylium Tosylate						
22.	W.S. 49	II	1.1	180-117 (178-116)	600	153-107 (146-103)
23.	LU.T. 50	IV	3.0	142-100 (140-99)	200	138-100 (118-92)

TABLE III. SUMMARY OF SIDE EFFECTS

Drug	Number of Patients	Constipation	Blurring of Vision	Diarrhea	Impotence	Nasal Stuffiness	No Ejaculation
Mecamylamine	14	14	5		4		
Bretylium tosylate	11					2	1
Guanethidine	19		1	8			10

Discussion and Conclusion

The desperate need for treating the more severe forms of hypertension, such as malignant hypertension and hypertension with complications (left ventricular hypertrophy, azotemia, papilledema, et cetera), cannot be disputed. The majority of the well-known antihypertensive drugs such as rauwolfia alkaloids, the thiazides and hydralazine (alone, or in combination)

too often are ineffective. Until recently, the ganglionic blocking agents, of which mecamylamine was our prime drug, were our only chemical compounds. However, the severity of their side reactions did not permit their full therapeutic application.

This year, two new agents which block transmission through adrenergic fibers specifically and which may replace the ganglionic blockers because they act similarly but without the disturbing by-effects have been introduced for the treatment of severe hypertension.

In order to compare and evaluate these new agents with what we consider the most effective of the ganglionic blockers (mecamylamine), we decided to make a preliminary study and analysis of twenty-three known hypertensive patients whose complete records were in our files.

Blood-pressure lowering was achieved with all three agents. On the basis of potency per mg., it would appear that mecamylamine is the most potent antihypertensive agent. However, this is of little importance when one considers the freedom from the undesirable side effects, that is, constipation induced by mecamylamine as compared to guanethidine. A few patients who did not respond to mecamylamine did so on guanethidine.

Moreover, the absence of side effects with the use of guanethidine and the potency of the drug made it possible to achieve a greater lowering of blood pressure with a smaller number of tablets than mecamylamine. A distinct advantage of the change from mecamylamine to guanethidine was the elimination of the necessity for laxatives or prostigmine to control constipation, and the simplified medical regimen.

The greatest limiting factor in the use of mecamylamine is the undesirable side effect of parasympathetic blockade. The most undesirable feature of bretylium was the need for large numbers of tablets to obtain an adequate blood pressure lowering and the fact that tolerance developed rather early in patients.

The average daily dose of the three drugs was as follows:

Mecamylamine	16 mg. per day
Bretylium tosylate	1,066 mg. per day
Guanethidine	35 mg. per day

It should be mentioned that the relatively low total daily dosage of ganglionic blocking agents or sympathetic inhibitors used in these patients with severe hypertensive disease was probably due to the concurrent use of the milder acting antihypertensive drugs.

In many cases, reserpine, ranging from 0.25 mg. to 0.5 mg. per day or whole root rauwolfia up to 400 mg. per day, hydralazine up to 400 mg. per day and chlorothiazide up to 1 gm. per day, or hydrochlorothiazide to 100 mg. a day or benzhydroflumethiazide, 10 mg. per day, were being used. To illustrate, patient L.T. (Case 18) required only 200 to 400 mg. per day of bretylium tosylate to maintain average weekly standing diastolic pressures below 90. The patient had reversed malignant hypertension (due to pyelonephritis) but had been on long-term treatment for several years with reserpine 0.5 mg. q.a.m., chlorothiazide 0.5 gm. q. 12 hr. and hydralazine 100 mg. q.i.d., so that the amount of drug used (bretylium tosylate) actually is not indicative of the total dosage of antihypertensive agent needed for satisfactory blood pressure control.

We recommend that every patient treated with any of these potent autonomic blocking agents be educated in the use of a blood pressure cuff and stethoscope. Standing systolic blood pressure as determined by the patient or a member of his family should be a guide to avoiding dangerous overdosage.

With guanethidine, adjunctive drug therapy and a patient well educated in home blood pressure recordings, the chemical control of severe hypertension can be achieved. Guanethidine is the drug of choice when rauwolfia, thiazides or hydralazine (singly, or in combination) have failed in the treatment of established diastolic hypertension.

As a result of our study, we would conclude that guanethidine demonstrates definite superiority over the other two agents—both from the point of view of therapeutic effectiveness and in the important area of lessened or innocuous side effects.

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Comparative Evaluation of Oral Cholecystographic Media

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IN RECENT YEARS several new media for oral cholecystography have been introduced, many showing distinct advantages over older media. There has thus been continuing progress and refinement in cholecystography since its first introduction in 1924 by Graham and Cole,[1] who utilized intravenous injection of calcium tetrabromphenolphthalein for gallbladder opacification. Soon thereafter the oral method was described by Menees and Robinson[2] and by Whitaker et al[3]—the former using sodium tetrabromphenolphthalein and the latter sodium tetraiodophenolphthalein.

Priodax, introduced by Kleiber in Germany in 1940[4] and quickly adopted in this country,[5] was generally considered the standard medium for cholecystography until the introduction of Telepaque in 1951,[6,7] Monophen appeared at about the same time as Telepaque,[8] and in 1953 Teridax was introduced.[9] Telepaque has generally been considered superior to all of the other above-mentioned media as indicated by various clinical trials.[6,9-12] We have used Telepaque as our standard medium from 1953 until the time of this study having found it superior to both Priodax and Teridax in our own unpublished trial series also.

In 1958 we were asked to subject a new oral cholecystographic medium, Orabilex, to a clinical trial, and at almost the same time we were also asked to evaluate another new medium, Vesipaque. The latter has been evaluated in several other countries[13-15] but has not been described in the American literature. Only one significant comparative study of Orabilex with Telepaque has been reported[16] although the initial report on Orabilex by Teplick et al[17] did include comparison of these two media in a small number of cases. There has been no report of comparative studies on Vesipaque.

Since we had already established Telepaque as our standard and most efficient medium as indicated above, we decided to conduct an adequately large comparative clinical trial of these three media. After our study was completed our attention was directed to an unmarketed variant of Telepaque, labelled Telepaque-D,[18] and we therefore added a series of cases evaluating this compound as well. A total of 656 cases was examined—214 with Orabilex, 220 with Telepaque, 128 with Telepaque-D, and 94 with Vesipaque.

Since many articles have already appeared detailing the chemical composition, toxicity, physical properties, etc., of all of the above-mentioned compounds, we shall omit these details and submit here only a table of their more important characteristics for clarity (Table I). We will refer to these compounds by their propietary names as commonly used in this country. It should be noted here that since completing this trial series we have learned that Telepaque-D is chemically identical to Telepaque—differing only in the physical method of manufacture of the tablets. Telepaque-D tablets were made by first suspending Telepaque in liquid prior to mixing with the starch vehicle of the tablet, rather than mixing dry as in the usual method of manufacture of Telepaque tablets.[18]

Method

Our standard method of administration of Telepaque, which we had used for many years, was followed in evaluating each of the contrast media. The cases to be evaluated were not selected in any way, both hospital cases and out-patients being in-

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TABLE I. COMPOSITION OF ORAL CHOLECYSTOGRAPHIC MEDIA

Proprietary Name (U.S.A.)	Other Proprietary Names (Europe)	Generic Name	Chemical Formula	Iodine (Per Cent)
Orabilex	—	Bunamiodyl	3-(3-butyrylamino- 2:4:6- triiodophenyl—2-ethyl sodium acrylate	57.0
Telepaque	Bilijodon	Iodopanoic acid	3-(3-amino-2:4:6-triiodophenyl—2-ethyl propanoic acid	66.7
Vesipaque	Biliodyl Baygnostil	Phenobutiodil	1-(2:4:6-triiodophenoxy)-butyric acid	68.2
Teridax	Trilombrine	Triiodoethionic acid Iophenoxic acid	α-ethyl-β-(2:4:6-triiodo-3-hydroxyphenyl)-propionic acid	66.5
Monophen	—	—	2-(4-hydroxy- 3:5-diiodophenyl)-cyclohexane carboxylic acid	52.2
Priodax	Biliselectan Pheniodol Bilitrast	Iodoalphionic acid	β-(4-hydroxy-3:5-diiodophenyl)-α-phenyl propionic acid	51.5

TABLE II. SIDE EFFECTS

(Total Number of Cases)	Orabilex (214)	Telepaque (220)	Telepaque-D (128)	Vesipaque (94)
	Per Cent	*Per Cent*	*Per Cent*	*Per Cent*
Gastrointestinal—mild (total)	21.0	29.0	16.5	24.4
Mild nausea only	14.0	7.0	8.0	12.8
Mild diarrhea or cramps	7.0	22.0	8.5	11.6
Gastrointestinal—moderate	4.4	20.4	32.1	20.2
Gastrointestinal—severe	0.2	2.2	5.6	6.4
Other (mild)	11.2	0.0	2.4	7.4
No side reaction	63.3	48.2	42.1	41.5

cluded. Following a fat-free evening meal, a minimum of six tablets or capsules was given with one additional tablet or capsule for each 25 pounds of body weight over 150 pounds. Films were made early the following morning and followed by fluoroscopic spot-filming, decubitus films, or other special projections as indicated if the gallbladder was visualized. If no visualization or extremely poor visualization was obtained a double dose of the same medium was given that evening and repeat roentgenograms were made on the following morning. In each case where gallbladder opacification was obtained a high-fat meal was given, followed by a final film fifteen minutes after the high-fat meal for visualization of the biliary ducts.

Side Effects

Each patient was asked about the occurrence and severity of any unusual symptoms or side effects after the ingestion of the gallbladder tablets or capsules, caution being used not to exaggerate the possibility of symptoms in the patient's mind. The relative frequency of side effects for each medium is indicated in Table II. It is apparent that Orabilex gave rise to a significantly smaller percentage of side effects than any of the other media tested, particularly in the moderate or severe range of gastrointestinal symptoms. Although mild nausea occurred considerably more often with Orabilex than with Telepaque, the reverse was true of mild cramps and diarrhea.

Of our entire series of 656 cases only one case had a severe reaction to oral cholecystographic medium. This occurred following the oral administration of six capsules of Orabilex to a seventy-six-year-old woman who experienced severe nausea, vomiting, and diarrhea the same evening and became moderately hypotensive by the following morning. It should be noted that this patient had been admitted in coma with deep jaundice and a low, unstable blood pressure, and it was therefore believed that her reaction was probably due to her already weakened, unstable condition. Recovery from the hypotension was fairly prompt with supportive treatment, and no permanent ill-effect resulted. This reaction was not considered to be due to any specific property of Orabilex but might well have occurred with any of the modern cholecystographic media.

It is again emphasized that oral cholecystography with any of the modern media is an eminently safe procedure and reactions such as the one cited above are exceedingly rare. Caution should be used, however, in administration of these media to patients who are seriously ill, especially those who are dehydrated or who already have severe gastro-intestinal irritability.

Gall-Bladder Opacification

The degree of opacification of the gall bladder was graded as non-visualization, poor visualization, good opacity, and excellent opacity. The results of this evaluation are given in Table III. The most significant figure is considered to be the sum of the percentages of good and excellent opacification, since

it is in these cases that visualization is considered to be diagnostically most accurate. Orabilex is seen to be definitely superior to Telepaque in this regard with Telepaque-D and Vesipaque being slightly less efficient than Orabilex.

TABLE III. GALL-BLADDER OPACIFICATION

(Total Number of Cases)	Orabilex (214)	Telepaque (220)	Telepaque-D (128)	Vesipaque (94)
	Per Cent	*Per Cent*	*Per Cent*	*Per Cent*
None	11.6	14.1	10.9	9.6
Poor	8.8	20.5	12.5	20.2
Good	21.4	28.2	22.7	37.2
Excellent	58.0	37.3	54.0	33.0
Total good and excellent	79.4	65.5	76.7	70.2

Bile-Duct Opacification

Visualization of the biliary ducts of some degree was obtained in about one-half to two-thirds of cases with the various media tested, with the greatest percentage of visualization of the ducts occurring with Vesipaque as indicated in Table IV. Good to excellent visualization, however, was seen in only about 30 to 35 per cent of cases and as indicated in Table IV these results were the same with all of the media used (within the limits of statistical variation).

TABLE IV. BILIARY DUCT VISUALIZATION

(Total Number of Cases)	Orabilex (214)	Telepaque (220)	Telepaque-D (128)	Vesipaque (94)
	Per Cent	*Per Cent*	*Per Cent*	*Per Cent*
None	44.0	53.4	50.1	35.1
Poor	21.1	14.1	19.0	28.7
Good	19.4	17.2	17.2	25.5
Excellent	15.2	14.1	13.4	10.6
Total good and excellent	34.6	31.3	30.6	36.1
Total visualized	55.7	46.2	49.3	64.8

Bowel Opacity

The presence of residue of contrast material in the bowel, particularly in the right colon, has frequently been commented on in the evaluation of various cholecystographic media, with considerable variation in opinion as to its significance. We are including an evaluation of bowel opacities seen with the various contrast agents for the sake of completeness (Table V). It is seen from the figures in Table V that the greatest frequency and most dense residual bowel opacities are obtained with Telepaque, all of the other contrast media showing lesser occurrence of bowel residue and particularly, less dense opacities. We do not consider this of any great significance in evaluating the efficiency of the contrast media, since we have not found opaque bowel residue to be nearly so great a problem in evaluation of the gallbladder as is the presence of gas in the colon.

Effect of Double-Dose Studies

We have always considered the utilization of a double dose of contrast material immediately following non-visualization or poor visualization with a single dose to be of considerable importance in obtaining accurate evaluation of the gallbladder. This opinion was borne out in this series in which a total of 135 cases received a double dose of contrast material (Table VI). Improvement in visualization with the double dose study as compared with the single dose occurred in anywhere from one-fifth to three-fifths of the cases so examined, with apparently the least effectiveness of this double dose when using Telepaque and the greatest effect with Vesipaque.

Summary and Conclusions

A series of 656 patients was examined for evaluation of newer oral cholecystographic media comparing our previous standard, Telepaque, with Orabilex, Vesipaque, and Telepaque-D, with the following results:

1. The lowest percentage of side effects was obtained with Orabilex and the best opacification of the gallbladder was obtained with Orabilex, Telepaque-D and Vesipaque being only slightly less efficient and Telepaque considerably less efficient. It is therefore concluded that Orabilex is the medium

of choice for oral cholecystography both as to its efficiency in gallbladder opacification and in its significantly greater freedom from side reactions. This conclusion is substantially in agreement with that of Whitehouse and Fink.[16]

TABLE V. RESIDUAL BOWEL OPACITIES

(Total Number of Cases)	Orabilex (214)	Telepaque (220)	Telepaque-D (128)	Vesipaque (94)
	Per Cent	*Per Cent*	*Per Cent*	*Per Cent*
None	20.2	12.2	24.3	27.6
Faint	50.0	25.0	46.1	32.9
Moderate	25.5	26.2	23.6	31.9
Dense	4.4	36.4	5.6	7.4

2. The degree of opaque residue in the bowel is considerably greater with Telepaque than with the other media but this is not considered to be a factor of any great significance.

3. The percentage of visualization of the biliary ducts is not sufficiently different with the various media tested to be considered an important factor.

TABLE VI. EFFECT OF DOUBLE DOSE

(Number Given Double Dose)	Orabilex (38)	Telepaque (34)	Telepaque-D (40)	Vesipaque (33)
	Per Cent	*Per Cent*	*Per Cent*	*Per Cent*
Non-visualization	55.6	58.8	32.2	21.6
No improvement	7.8	5.8	20.0	12.2
Improved visualization	36.6	35.4	47.8	66.2

4. Double dose studies may be needed with any contrast medium, the effectiveness probably varying more with the individual case than with the medium employed.

5. Telepaque-D, though chemically identical to Telepaque, seems to be superior to it as regards gallbladder opacification and absence of bowel residue. Side effects are almost identical with the two. The difference in their efficiency may be due to the physical method of suspension of the agent, possibly permitting better absorption of Telepaque-D from the intestine.

Addendum

Since the completion of this survey, Orabilex has been adopted as the standard cholecystographic medium at Detroit Receiving Hospital and during the past 18 months approximately 2200 oral cholecystograms have been performed with this medium with no significant side reactions and with the same general results as had been described in this article.

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(Continued on Page 362)

Functional Bleeding—A Metabolic Disease?

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FUNCTIONAL uterine bleeding has been one of the more confusing problems in gynecology. This may be so because we have not focused our attention on a new concept and its possible relationship to this disorder. Evidence is accumulating that functional bleeding may be a manifestation of a specific biochemical deficiency of metabolic significance. Our shortcoming has been that we have always considered the action of female hormones to be directly on the end organs. We have given no consideration to intermediary mechanisms. Yet, current investigations indicate that enzymatic intermediary reactions play a very significant role in endometrial cellular reproduction.

Since the development of methods for the demonstration of alkaline phosphatase in tissue sections, the presence of this enzyme in the endometrium has become well established. Quantitative histochemical studies indicate that the presence and activity of this enzyme is not constant throughout the menstrual cycle. It is also known that the enzymatic activity is highest during the proliferative phase and is reduced during the secretory phase and disappears completely before menstruation. The effects of the steroid sex hormones on alkaline phosphatase in the endometrium has also been noted. Estrogen produces a marked increase in the phosphatase activity in the epithelium of the endometrium, which effects are not duplicated by either progesterone or androgen. Further, a direct relationship exists between the amount of estrogen present and the degree of enzymatic response. Prolonged estrogen administration causes additional phosphatase deposition and intensifies the enzymatic activity. It is known that histologically, prolonged estrogen administration produces hyperproliferation of the endometrium. It is important to note that this enzymatic activity is synchronous with the other morphological changes produced by estrogen on the endometrium. By these facts, it is most probable that the cyclic variation in the enzymatic activity of alkaline phosphatase and in tissue proliferation, is related to the cyclic variation of estrogen production. Thus, there is a relationship established between the amount of estrogen, the amount of alkaline phosphatase, and the amount of tissue growth in the endometrium. Attention is also called to the coincidental appearance of alkaline phosphatase in the endometrium and the deposition of glycogen. This suggests that there is the simultaneous integration of estrogen, alkaline phosphatase, and deposition of glycogen confined to a period of extremely active endometrial growth.

This association between alkaline phosphatase, estrogen, glycogen, and cellular growth is not peculiar to the endometrium alone. Investigators have established that alkaline phospho-monoesterase is an invariable concomitant of normal bone formation. Histochemical techniques have corroborated these findings. Glycogen and phosphatase are not only present together in tissues which calcify, but no calcifying tissues are devoid of either of these substances. It is thus concluded that alkaline phosphatase and glycogen play an essential role in the process of calcification and bone growth. Likewise, the role of estrogen in calcification and bone growth is well known. This is exemplified by the greatly advanced bone age in female infants with abnormally high estrogen levels as in granulosa cell tumors. Thus we can see that if phosphatase and glycogen are indispensable to bone growth and calcification and estrogen promotes this same physi-

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ological activity, then it must do so not directly, but through some intermediary process in its relationship with alkaline phosphatase.

In the kidney, phosphatase has been found most highly concentrated in the proximal convulted tubules —exactly in conformation with the hypothesis that phosphatase is concerned in glucose resorption, since resorption has been shown to occur only in the proximal tubules. Tubular phosphatase has been discovered in representatives of all vertebrate classes with one significant exception—the aglomerular toadfish, *Apsanus Tau*, which can neither excrete nor secrete sugar. The conclusion that alkaline phosphatase is part of the glucose resorbing mechanism is inescapable.

Other researchers state that it is generally agreed that a phosphyorylating intermediary is a necessity for glucogenesis. The transformation of hexosephosphate into glycogen requires the presence of a phosphate splitting enzyme. Of the various enzymes capable of such action, alkaline phosphatase has been invoked because of its ubiquitous occurrence and because of its demonstrated capacity to utilize the particular substrates which serve as intermediates in carbohydrate metabolism. Further, the hypothesis that phosphatase is found in tissues in regions supervening between the source of sugar and the location in which glycogen deposition is occurring has been adequately demonstrated to be correct. In the uterus, a region containing phosphatase is invariably interposed between the blood stream and the locality in which glycogen is deposited. It is also noted that the dephosphorylation of hexosephosphate by alkaline phosphatase is a necessary antecedent to glycogen formation. The effect of estrogen in raising blood sugar levels and liver glycogen is also noted.

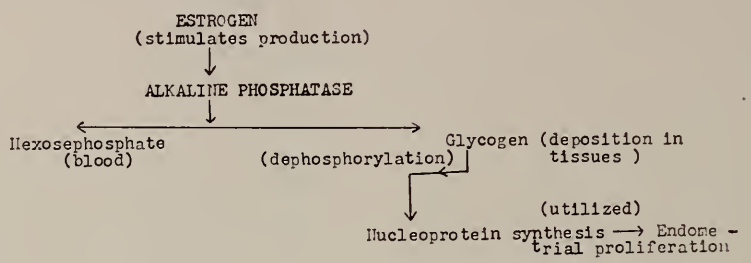


Fig. 1

From the aforementioned evidence, it becomes plausible that the appearance of increased alkaline phosphatase in the endometrium is not coincidental, but represents a specific function of estrogen. Also, endometrial proliferation is not the result of direct estrogen action, but rather is mediated through this enzymatic system. The mechanism is suggested in Figure 1.

This mechanism suggests a corollary that estrogen has an effect only on tissues in which alkaline phosphatase is demonstrated. There is evidence suggestive that this is true.

The knowledge of the biochemical role of alkaline phosphatase is certainly deficient, but its extreme importance as an enzyme in endometrial cellular reproduction is becoming apparent. As more information becomes known about its exact role in this process, it is probable that the symptom which we have been calling functional uterine bleeding will in reality be found to be an enzymatic metabolic disorder. The defect may stem from an over accumulation of substrate that ordinarily is converted into other substances by the enzyme, or that an abnormal enzyme is manufactured by the patient. In any event, it is now clear that a better understanding of endometrial growth and menstrual disorders is dependent on an elaboration of our knowledge of the significance of alkaline phosphatase.

ORAL CHOLECYSTOGRAPHIC MEDIA

(Continued from Page 360)

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Care of the Aging

Before and since the inauguration of President Kennedy, the most prominent topic in newspapers and magazines and of radio announcers is the care of the aging. Through its House of Delegates, the Michigan State Medical Society has taken a stand and outlined a position of private medical service on this subject. The American Medical Association has done the same.

On every hand doctors are subject to comments, criticisms and accusations, alleging that over 16 million "over 65" persons are without medical care in their years of need. These facts and figures have been corrected innumerable times but they are still being repeated.

During the campaign, Mr. Kennedy criticized the general tax measure under which the "over 65" are now eligible for care—the Kerr-Mills bill. This bill provides that persons under a specified income limit or in case of distress may have special attention, the government paying part or sufficient amount to give them care. The federal government gives matching funds from the general treasury. State and county funds also come from the local tax funds. This puts the care of the needy and aging specifically on general taxation where it has always been. This is no change in philosophy but it is a definite change in amount of care and availability of it.

Mr. Kennedy offered his plan putting health care of the aging under Social Security which he said was not a tax. This, he said, would remove these people from the tax load. His plan, the Forand-type plan, puts all beneficiaries of Social Security under hospital and medical care and under what "is not tax or insurance."

Social Security is definitely an accepted and valuable means for caring for the dependents, widows, orphans, et cetera, of those who have carried the Social Security program. The amounts are specified very distinctly and come from compulsory deductions from wages from almost everybody in the country except the medical profession. This deduction applies to the first $4,800 earned with no deduction for anything. It takes the percentage from the first dollar to the 4800th dollar for the purpose for which it was intended. We are willing to concede its justification as a basic income for the retiree but when it comes to taking care of the health of all the retired and aged persons including those who were never under Social Security, it is a very unfair tax. Moreover, no one has questioned that the Social Security system is sound fiscally or actuarially.

Social Security Tax

Medical and health care of the aging and needy is an essential program. It has always been accepted and administered in various ways. To load that whole group on the low income people is completely unfair and that is exactly what is proposed. Income over $4,800 is not taxed or assessed or withheld for Social Security. The higher income people who are the ones most able to help in the care of the needy are exempted under Kennedy's plan.

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The Kerr-Mills bill (the AMA-supported plan) takes care of these people using general taxes, much of these taxes coming from the higher incomes. Social Security has great promise, but it was never intended to take on this extra load. If general medical and health care of all over 65 should be adopted by the federal government, we must anticipate those rates, instead of being a quarter of 1 per cent as suggested, will be multiplied 100 times at least. That happened in Germany and other nations where this compulsory health program is in operation.

Another Insurance Rate Adjustment

On January 10, 1961, Michigan Blue Shield and Michigan Blue Cross both filed for rate adjustment with the State Insurance Commissioner. The immediate result was a blast from the press, from labor, and from the Insurance Commissioner claiming he was receiving hundreds of letters protesting against the rate increase, and not one for it.

About a year and a half ago Blue Shield filed a rate adjustment of 19.5 per cent to meet extended benefits, increased utilization and costs. The Commissioner held public hearings and on July 1, 1960, authorized an increase of 11.5 per cent with specific instructions: Blue Shield was to come up before July 1961 with a definite program to eliminate all abuses, to answer criticisms, and to supply a program which could give the services required with a guaranteed rate to last two years. He should not have been surprised when this new request came because it was ordered by his department and his own letters of authority.

Five Years—No Help

In 1955, Michigan Hospital Service asked for a rate increase, not Michigan Medical Service. Many interested persons registered their protest and the Governor decided to appoint a Commission not only to study Blue Cross, but also Blue Shield (which was only involved by association), "to determine how better and more complete service could be rendered for less money." This commission started work on February 13, 1956, and continued until April 26, with almost daily reports in the public press—front page articles, and so on.

The Commission finally reported that it could not answer the problem and recommended a study be done at the University of Michigan by suggested experts. After some time negotiating and searching, the Kellogg Foundation agreed to finance the program up to $382,000. A study was started which involved many visits and much searching of the Blue Cross and Blue Shield records, attending Blue Cross and Blue Shield meetings, etc. The report was promised for not later than May 1959. Before that study was available it became necessary for Blue Shield to have a rate increase which was requested, delayed and finally granted in 1959, but the amount was cut very seriously and was inadequate.

The inadequacy of that rate brought the request a year and a half ago which resulted last July in an increase of 11.5 per cent. The 11.5 per cent was less than was requested. Two appeals have been necessary for increased rates since that Governor's Commission study was started. This is the second request *since that report was promised.*

The Michigan State Medical Society, Michigan Medical Service, Michigan Hospital Association and Michigan Hospital Service, all agreed with the purposes and concepts of this study, have cooperated in every way possible, hoping the report might determine if there are faults or imperfections in the two plans or what is necessary to make them better. Both have made their own studies and believe there are no radical imperfections.

The constantly increasing costs of everything—living, wages, salary, and the vastly extending quality and extent of hospital and medical service has been responsible for most of the increases which have been requested. The study growing out of the Governor's commission should be available. What has become of it? The Blue Plans for whom it was invoked and the public service corporations caring for the life and health of our citizens should be allowed to see these reports. Senator McNamara and some representatives to the President's Conference on Aging workers had them and quoted from them. Michigan Medical Service auditors and actuaries said four years ago that the rate set up at that time, if it had been granted, would carry through for years, the same as the original rates for 1942 carried for 12 years.

It is hoped the Commissioner, this time, will grant the full request. This one is guaranteed by the actuaries to last two years if granted in full. At the end of that time an increase corresponding with the Department of Commerce cost of living would probably carry it through. It would be very interesting to tie the cost of living to the rate for these Blue Shield programs.

Thank You!

This number of THE JOURNAL is devoted to Rheumatism and Arthritis, and we are indebted to J. J. Lightbody, M.D., of Detroit, for his tireless assistance in assembling the material offered.

Guest Editorial

Clinical Laboratories—How High the Cost?

Recent publicity about use of commercial laboratories should serve to warn us of the responsibilities of the physician to his patient when ordering laboratory tests. "Larceny in the Labs" (*Time*) and "The Deadly Mistake" (*Newsweek*), both appearing in the October 24 issues, deal with the appalling situation in New York City, where 75 per cent of a sampling of 130 laboratories erred on simple blood groupings. Lay laboratories offering inducements such as flat-rate service have been found running laboratory "production lines" with little or no attempt at maintenance of professional standards.

What is the situation in Michigan? Recently there has been an active solicitation of practicing physicians by certain non-physician clinical laboratories. In some of the printed material there are statements implying that the services of pathologists are available through these laboratories. The Michigan Pathological Society has unanimously reiterated its opposition to such a liaison. Furthermore it feels that *no* physician should be associated with a lay laboratory under arrangements which tend to interfere with or impair the free and complete exercise of medical judgment and skill or tend to cause a deterioration of the quality of medical care.

A major attraction proposed by the lay laboratories is lower cost per test. The College of American Pathologists Code of Ethics specifically states that pathologists shall not compete for laboratory services on the basis of fees; much study and research has been spent by members of the Michigan Pathological Society in preparing a recommended list of fees which can serve as a guide for setting laboratory fees to conform with local situations. Is the cost of using lay laboratories really low? What is the *real* cost? Is it economy to jeopardize the patient? Is it economy to imperil the free practice of medicine by forcing further restrictive legislation upon us all? And is it economy to deal so lightly with the physician-patient relationship?

Pathologists not only take formal training in the supervision of clinical laboratories, they are, for the most part, actively participating in continuing programs of education in order to keep abreast of advances in this field. They consider clinical pathology an integral part of the practice of medicine. Don't you?

PUBLIC RELATIONS COMMITTEE
Michigan Pathological Society

AMA for All M.D.'s

I believe every physician in this country—practicing or not—should be a member of the American Medical Association.

By this I mean that every doctor should have a full voting membership. Although the AMA numbers almost 179,000 members, there are approximately 20,000 physicians who, in my opinion, should be members of the association but are not.

The problem of how to get all physicians active in the AMA is one that has worried us for some time. We like to think that the AMA is for all doctors of medicine, and it certainly should be.

As you know, membership in the AMA demands membership in the local medical society. Only government-employed physicians are exempt.

Some of the recommendations to the House by the Board of Trustees, which I strongly support, are:

—State and county societies should grant membership to physicians holding licenses in any other state, as well as to those physicians whose activities do not demand licensure.

—Constitution and bylaw provisions which restrict voting membership to private practitioners should be repealed, along with any requirements imposing long-term residency.

—Programming should be re-evaluated so that medical society meetings will interest and attract non-practicing as well as practicing physicians.

The increase of the number of physicians not in private practice has paralleled the climbing proportion of medical care which is being administered by physicians not in private practice.

This influence is not confined to physicians in government; it can also be seen in certain developments.

1. The steadily rising number of physicians in hospital service.
2. The recent policies of medical schools which call for an increase of full-time faculty personnel.
3. The employment of physicians by consumer and labor-sponsored plans and the slow but consistent growth in the number of these plans.
4. The employment of more physicians by industry and the expansion of occupational health programs to include both preventive and treatment services.

Therefore, the number of physicians who are not in private practice is a large, growing, and influential portion of the physician population.

My sole desire is to attract *all* physicians into the medical societies. To do this, we must retain our leadership in the scientific field and gain leadership in the socio-economic field.

E. VINCENT ASKEY, M.D.
President American Medical Association

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Michigan State Medical Society

Annual Session of The Council

January 26-28, 1961

HIGHLIGHTS

All members of The Council were present at the Annual Meeting in January, except one detained by illness. Guests included Michigan Health Commissioner A. E. Heustis, M.D., Lansing; Michigan Medical Service President G. Thomas McKean, M.D., Detroit; C. J. Tupper, M.D., of Ann Arbor, representing the Dean of the U-M Medical School; Gordon H. Scott, Ph.D., Dean, Wayne State University School of Medicine; L. Gordon Goodrich, MMS Executive Vice President; Peter G. Klein, representing Michigan Hospital Service; Mr. Joseph Miller of the American Medical Association (Field Representative).

One hundred forty-two (142) items were presented to The Council, chief in importance being:

- Secretary's Annual Report was approved (see page 369).
- Treasurer's Annual Report was approved (see page 372).
- Editor's Annual Report was approved with commendation (see April JOURNAL).
- Reports of the County Societies Committee, the Finance Committee and the Publication Committee, all Standing Committees of The Council were approved, as amended by the Reference Committees.
- Auditor's report for the year 1960, and the Budgets for the year 1961 were thoroughly considered and approved (see pages 372-378).
- Elections: Secretary D. Bruce Wiley, M.D., Utica; Treasurer W. A. Hyland, M.D., Grand Rapids; Editor Wilfrid Haughey, M.D., Battle Creek, were re-elected for the year 1961.
- Progress Report on Michigan Hospital Service (Blue Cross) was presented by Mr. Klein in behalf of MHS President John N. Lord.
- Progress Report on Michigan Medical Service (Blue Shield) was presented by President McKean.
- Recognition of Medical Assistants. Upon suggestion of Advisory Committee to MSMAS, The Council authorized The Journal Editor to recognize in JMSMS the contributions made by the Michigan State Medical Assistants Society.
- M.D. Teenage Clubs. The Council took action to encourage every component society to promote medical students' clubs in high schools, junior colleges and colleges, and requested the appropriate committee to further this and similar methods for the recruitment of high grade medical students.
- The Finance Committee recommended the following policy covering travel by MSMS officers, members of delegations and committees, and personnel: MSMS shall pay transportation allowance not to exceed the cost of first class travel to and from destination by a plane or train plus actual hotel and meal expense for all meetings authorized by The Council; state and local travel by car is to be paid at the rate of $.08 per mile, as in the past. This policy was approved by The Council.
- Progress report on new MSMS headquarters building was presented by President Kenneth H. Johnson, M.D., of Lansing. A move into the new headquarters in April is planned.
- Recent Memorial Gifts have been presented by Mrs. L. Fernald Foster of Detroit, and by the family of the late Ralph W. Shook, M.D., of Kalamazoo. Also presented was a gift of $1,000.00 by Doctor and Mrs. W. S. Jones of Menominee. W. M. LeFevre, M.D., of Muskegon is working with architect M. Yamasaki in sculptoring a master mold for the bronze-colored aluminum medallion to be installed over the front entrance of the new building, between the central columns.

- A report from Michigan Medical Service on its follow-through of 1960 MSMS House of Delegates requests and actions concerning Blue Shield was received as information.
- The Council authorized Chairman H. J. Meier, M.D., of Coldwater to present a statement on behalf of MSMS at the public hearings on the Blue Shield rate increase request.
- Chairman Meier reported that the fluoridation case of Margaret Jones vs. the City of Highland Park (Michigan) resulted in a dismissal of the case without trial.
- President Johnson appointed the new Medical Care Study Committee as per instructions in Resolution No. 1 of the 1960 House of Delegates, with H. F. Falls, M.D., of Ann Arbor as Chairman; the President also appointed the Blood Banks Committee with R. L. Mainwaring, M.D., of Dearborn as Chairman, and the Rural Medical Service Committee with H. B. Zimmer, M.D., of Lapeer as Chairman.
- A special Secretary's Letter to component societies was authorized to alert them re the Michigan Association of the Professions Congress in Detroit, February 22-23-24, and to the United States Chamber of Commerce Aircade scheduled for Detroit, March 1.
- At the suggestion of Speaker J. J. Lightbody, M.D., Detroit, The Council took action on two reports left unresolved by the 1960 House of Delegates: (a) it accepted the minutes of the one committee meeting held by the Permanent Advisory Committee on Fees in lieu of a formal annual report of that Committee, and (b) it approved the annual report of the Committee to study problems of malpractice. The Council urged the inclusion of malpractice prevention as a valuable subject on component society meeting programs at least once every second year with either an MSMS Councilor or the Chairman of the MSMS Study Committee to be on these programs.
- Speaker J. J. Lightbody of Detroit reported he had appointed the four committees of the House of Delegates.
- Congratulations and commendations were ordered sent to C. Howard Ross, M.D. of Ann Arbor for the excellent work he is doing in socioeconomic education of seniors at U-M Medical School.
- Legal Counsel Lester P. Dodd's report included opinions covering: (a) the principles applicable to the liability of "referring physicians" and "consultants"; (b) concerning statement of principles and resolution of intent with respect to governmental medical program; (c) opinion re admission of others than doctors of medicine to the staff of a hospital originally organized under the county sanatorium act; (d) report on the trial of "Gonserton," a Bay City corporation found to be in violation of the medical practice act and enjoined by the court from further operation and advertising.
- President-Elect Otto K. Engelke, M.D., Ann Arbor, praised the Wayne County Medical Society for sponsoring a highly successful legislative dinner on January 20, 1960.
- Matters of mutual interest were discussed with Assistant Dean Tupper of U-M, with Dean Scott of Wayne State Medical College, and with Michigan Health Commissioner Heustis.
- Directory of Members. The Council instructed that the Directory be published every second year (1962, 1964, 1966 et seq.).
- The Journal. Due to lessened advertising, The Council recommended that the Publication Committee give serious consideration to reduction of the total number of pages in each issue of The Journal in order to reduce production costs and operate within the estimated budget.
- Committee Meetings. The Council instructed that a memorandum be sent to all committee chairmen urging that all committee meetings when feasible be held in the new MSMS headquarters in East Lansing as soon as the new building is completed.

- County-State Society Nights: The Council was of the opinion that these nights are arranged for the purpose of discussing county society-state society problems, and that such formal programs might well be limited to MSMS and county society representatives; this suggestion is to be offered to all component societies.
- The Council recommended that component societies enter into discussions on the Mills-Kerr legislation and Medical Aid to the Aged (MAA) with representatives of their respective (county or district) welfare departments.
- Each Councilor rendered a report on the condition of the profession in his individual District.
- Magazine articles unfavorable to Medicine. Numerous articles containing one point of view and frequent inaccuracies, on a national scale, are appearing in magazines. The Council petitioned the American Medical Association to prepare statements on each article appearing in a national magazine unfavorable to Medicine, that this statement be released to all news outlets and state and county medical societies, and that AMA Officers and Delegates make personal calls upon the magazine editors or publishers in an effort to prevent repetition of irresponsible journalism.
- Committee reports. The following were considered: (a) Maternal Health Committee, meeting of January 12, with personal presentation by Chairman Francis Jones, M.D., of Lansing; (b) Progress report on Relative Value Study, a special report from Chairman Luther R. Leader, M.D., Detroit; (c) National Defense Committee, meeting of November 30, and resignation of Max L. Lichter, M.D., of Melvindale as Chairman, due to his increased participation in AMA Counsel on National Defense activities; (d) Prevention of Highway Accidents, November 10; (e) Committee to Study Establishment of Loan Fund for New Physicians, December 14; (f) Venereal Disease Committee, December 1; (g) Postgraduate Medical Education Committee, December 8; (h) 1961 Committee on Scientific Work Program, December 21; (i) Legal Affairs Committee, December 29; (j) Ad hoc Committee to Study Utilization of Health Insurance, January 4; (k) Mental Health, January 5; (l) Cancer Control Committee, January 12; (m) MCI Program Committee with Discussion Group Leaders, January 17; (n) Advisory Committee to Executive Director; January 27; (o) Committee to Streamline 1961 Midsummer Session of The Council, January 27; (p) Hospital Relations Committee, December 8; (q) Big Look Committee, January 28, also the Michigan Cancer Coordinating Committee minutes of meetings of December 15 and January 12.
- Reports. (a) On the second national Conference on the Medical Aspects of Sports, Washington, D. C., November 27, submitted by Robert E. Anderson, M.D., of Flint; (b) on AMA Conference on Civil Defense, Chicago, November 4-6, submitted by W. G. Gamble, M.D., Bay City.
- Appointments. (a) G. B. Saltonstall, M.D., Charlevoix, as MSMS representative to Board of Directors of Michigan Association of the Professions; (b) R. W. Teed, M.D., Ann Arbor, and K. W. Toothaker, M.D., Lansing, as Delegate and Alternate to Michigan Health Council for 1961; (c) The Council Chairman was authorized to appoint an MSMS representative to the golden anniversary of Joint Committee on Health Problems in Education, Chicago, March 8, and to the eighth national Conference on Physicians and Schools, Chicago, March 9-11; (d) C. P. Anderson, M.D., Detroit, was appointed Chairman and Grant L. Otis, M.D., of Jackson, Vice Chairman of the MSMS National Defense Committee.
- Public Relations Counsel H. W. Brenneman's monthly report included report on White House Conference on Aging held in Washington, D. C.; on state legislation; on exhibiting at 1961 Michigan State Fair (sponsorship was approved by The Council); on the Michigan Constitutional Convention; on News Luncheon for the Michigan Clinical Institute to be held in Detroit, March 1.

ANNUAL REPORT OF THE SECRETARY

Presented to The Council

January 27, 1961

MEMBERSHIP

The Michigan State Medical Society membership for 1960 showed a total of 6,714 members, including 41 Military members, 387 Associate Members, 312 Life members, 88 Retired members and 6 Honorary members. The total paid membership was 5,877, with net dues of $380,356.29. The 1960 membership once again established a new record for the Society. The number of members with unpaid dues for 1960 was 28.

DEATHS DURING 1960

I must regretfully report a total of 98 deaths among members during the past year.

Bay County—Fred H. Drummond, M.D., Kawkawlin; John A. Freel, M.D., Bay City; E. Charles Hughes, M.D., Bay City; Paul R. Urmston, M.D., Bay City.

Berrien County—Kenneth H. Cowdery, M.D., St. Joseph.

Branch County—Robert L. Wade, M.D., Coldwater.

Calhoun County—Herman Beuker, M.D., Marshall; Joseph E. Rosenfeld, M.D., Battle Creek.

Chippewa-Mackinac County—LeRoy J. Wallen, M.D., Sault Ste. Marie.

Dickinson-Iron County—Cyril D. Klaus, M.D., Iron Mountain.

Genesee County—Robert L. Phillips, M.D., Nokomis, Florida; Karl F. Searles, M.D., Flint.

Grand Traverse-Leelanau-Benzie County—Mark F. Osterlin, M.D., Traverse City; B. H. VanLeuven, M.D., Empire.

Gratiot-Isabella-Clare County—Charles F. DuBois, M.D., Alma; Herbert F. Kilborn, M.D., Alma.

Houghton-Baraga Keeweenaw County—J. R. W. Kirton, M.D., Calumet.

Huron County—John Ritsema, M.D., Sebewaing.

Ingham County—J. Earl McIntyre, M.D., Lansing; Clifford G. Menzies, M.D., East Lansing; Ray A. Pinkham, M.D., Lansing.

Ionia-Montcalm County—John W. C. Fleming, M.D., Pewamo.

Jackson County—Arthur M. Schaeffer, M.D., Jackson; Edward T. Torwick, M.D., Jackson.

Kalamazoo County—Charles O. Holder, M.D., Kalamazoo; Amos S. Youngs, M.D., Kalamazoo.

Kent County—Henry M. Blackburn, M.D., Grand Rapids; Harold J. Damstra, M.D., Grand Rapids; Lucile R. Grant, M.D., Grand Rapids; George P. Graybiel, M.D., Caledonia; J. Winslow Holcomb, M.D., Grand Rapids; Horace C. Jones, M.D., Grand Rapids; Karl E. Seidel, M.D., Grand Rapids.

Lapeer County—Clarence D. Chapin, M.D., Columbiaville; Adolph T. Rehn, M.D., Lapeer.

Macomb County—S. E. Lerman, M.D., Warren; Morris H. Marks, M.D., Centerline.

Marquette-Alger County—Charles L. Hirwas, M.D., Marquette.

Muskegon County—J. P. Yegge, M.D., Muskegon Heights.

Oakland County—Leon F. Cobb, M.D., Pontiac; Albert Jacknow, M.D., Pontiac; Charles A. Neafie, M.D., Pontiac; George N. Petroff, M.D., Pontiac; Ross J. Porritt, M.D., Pontiac; Edward Stein, M.D., Oak Park.

Ontonagon County—Jesse L. Bender, M.D., Greenland.

Saginaw County—William H. Brock, M.D., Saginaw; Donald H. Howell, M.D., Saginaw; W. H. Pickett, M.D., Gainesville; Joseph L. Radai, M.D., Saginaw; Walter K. Slack, M.D., Saginaw.

St. Clair County—Lewis M. Carey, M.D., New Smyrna Beach, Florida; Evert W. Meredith, M.D., Port Huron.

Van Buren County—M. W. Buckborough, M.D., South Haven.

Washtenaw County—Theodore P. Eberhard, M.D., Ann Arbor; Warren E. Forsythe, M.D., Eugene, Oregon; Edwin C. Ganzhorn, M.D., Ann Arbor; James H. Maxwell, M.D., Ann Arbor; Christopher G. Parnall, M.D., Ann Arbor; Charles L. Washburne, M.D., Ann Arbor; Walter J. Wright, M.D., Ypsilanti.

Wexford-Missaukee County—Calvin S. Purdy, M.D., Buckley.

Wayne County—Robert E. Anslow, M.D., Detroit; Donald A. Bailey, M.D., Detroit; Saul E. Barnett, M.D., Detroit; Sidney Berman, M.D., Detroit; Edgar A. Bicknell, M.D., Detroit; Osborne A. Brines, M.D., Detroit; Richard A. Bruehl, M.D., Port Charlotte, Florida; Oreste A. Capano, M.D., Detroit; Charles W. Castrop, M.D., Dearborn; V. George Chabut, M.D., Northville; Charles H. Clifford, M.D., Southfield; Julius C. Clippert, M.D., Detroit; Frederick H. Cole, M.D., Detroit; Robert K. Dixon, M.D., Detroit; D. R. Donovan, M.D., Detroit; Anthony J. Font, M.D., Detroit; William Gramley, M.D., Detroit; Arthur S. Hale, M.D., Detroit; James A. J. Hall, M.D., Detroit; Wm. F. Hamilton, M.D., Detroit; John A. Hookey, M.D., Wyandotte; Charles G. Johnston, M.D., Detroit; Joseph O. Kopel, M.D., Detroit; Henry R. Leibinger, M.D., Detroit; Gordon B. Myers, M.D., Detroit; Everett H. Reed, M.D., Detroit; Charles A. Reinbolt, M.D., Farmington; Emil D. Rothman, M.D., Huntington Woods; John Schlemer, M.D., Detroit; Ward F. Seeley, M.D., Detroit; Charles J. Socall, M.D., Detroit; Ellis H. Steffensen, M.D., Detroit; Robert B. Toaz, M.D., Detroit; Peter E. Tuynman, M.D., Detroit; J. C. Williamson, M.D., Dearborn; William P. Woodworth, M.D., Detroit.

ORGANIZATIONAL ACTIVITIES

1960 Annual Session.—The past year the 95th Annual Session was held in Detroit with a total attendance of 4,094. This includes 2,266 doctors of medicine. The General Assembly type of program was continued.

1960 Michigan Clinical Institute.—The fourteenth Michigan Clinical Institute was held in Detroit, March 8-11. The total registration was 2,671 including 1,260 doctors of medicine. Again the Operating Room Nurses Conference and the Residents, Interns and Senior Medical Students Seminar were held in conjunction with the MCI.

Annual County Secretaries-Public Relations Seminar.—The 1960 County Secretaries-Public Relations Seminar was held on January 30-31, 1960, in Detroit, and was attended by 249, an increase over the previous year.

Communication with Membership.—As a part of the Society's general educational and informational program for individual members and for component county societies during the year 1960, five Secretary's Letters were issued, three to all members and two to County Society Officers. These informational bulletins were in addition to the monthly issues of THE JOURNAL with its scientific articles and informative news items.

In addition, four Legislative Bulletins were issued to 750 key men during the 1960 legislative sessions to keep the membership informed of activities in the State Legislature pertaining to the practice of medicine.

A new publication "Medical Economic Currents" was published, containing capsulated and charted facts of major interest. Two issues were sent to 1,000 MSMS members who have state and county responsibilities which place them in the position of developing policy and expressing medicine's position to the public. This publication also provided opportunity for reprinting of these charts in county medical society bulletins. Generous compliments on this informational bulletin have come to MSMS from many members.

FINANCES

An audit of the Society's books covering twelve months was completed by Auditor K. B. Knostman as of November 30, 1960. This has been submitted to the Finance Committee for study and is available to any member of the Society for perusal at the Executive Office. A brief summary of the audit produces the following information:

Assets:	
Cash	$ 39,794.72
Accounts Receivable	21,160.62
Investments	92,124.97
Property and Equipment	643,229.23
Other assets	1,004.15
Total assets	$797,313.69
Liabilities:	
Notes Payable (incl. accrued interest)	$150,681.59
Accounts Payable	94,457.71
Society Equities:	
Public Education Reserve	$ 35,000.00
Public Education Program	29,154.95
Public Service Account	2,985.15
Professional Relations Account	—6,189.64
Rheumatic Fever Program	1,436.22
Bldg. Maintenance Fund—606	—1,342.63
New Headquarters Fund	—31,737.25
New Headquarters Under Constr.	454,185.07
General Society Equity	68,682.52
Total Liabilities and Equities	$797,313.69

It should be noted that the financing of the New MSMS Headquarters Building, now nearly completed, involved the securing of additional funds from a commercial bank at a favorable rate of interest and the temporary use of the MSMS Public Education Reserve which also stands as an obligation of the MSMS to be eventually re-established.

THE JOURNAL

The following financial information relative to THE JOURNAL is found in the annual audit report of K. B. Knostman. Income was $135,073.74 which is $13,976.26 under the estimated budget for 1960 (this includes $8,733.62 from allocations of members' dues). Expenses were $146,648.57 which was $1,908.57 over the budget estimate for the year and resulted in a loss for the year of $11,574.83 on JOURNAL activities. The Publication Committee became aware early in the year of the substantial decrease in advertising revenues and for the final six months of the year decreased the number of pages in each issue in order to reduce production costs.

PUBLIC RELATIONS

In 1960, the public relations expenditures of MSMS were curtailed in recognition of necessary use of funds for other purposes. The Public Relations Committee has attempted to compensate by channeling available monies into activities producing the greatest PR rewards.

Postponed were plans for a Medical-Legal Conference on Investigation of Unexplained Deaths, a motion picture and brochure on the cost of medical care, and all County Fair exhibits except the Michigan State Fair. Dropped also were live surgical public telecasts.

Despite the decreased PR budget, The Council in July authorized a crash program called the Campaign for Freedom. Financing of this project was obtained by appropriation of necessary funds from the Public Education Reserve.

The public relations program of MSMS, through its Public Relations Committee, for 1960, was as follows:

Campaign for Freedom.—This was a two-phase program designed to (1) inform the doctors and their patients of the urgent need to oppose legislative plans to include medical care in the social security program, and (2) to explain the Mills-Kerr legislation which would enlarge the scope of public assistance programs.

The Campaign for Freedom held three regional meetings in the State to explain the plans and inspire local action. Subsequent mailings were sent to all MSMS members urging personal activity and the establishment of local Campaign for Freedom committees. Forty of these committees were established and successfully activated.

Two pamphlets were produced and more than 400,000 were distributed by doctors, their wives, medical assistants and friends.

Television and Radio.—Additional "Family Doctor" television shows were presented supplemented by appearances over established programs or on specially allocated periods. Cooperation was given to the Michigan Association of the Professions-Michigan Health Council TV program "Decision—the Moment of Truth," a program built to explain why professional people do-what-they-do-in-the-way-that-they-do-it and how to make best use of professional people. Several radio programs were originated by MSMS and participation by MD's in these programs was outstanding. Continued support was given the U. of M. health series broadcast in tape over local radio stations.

Intra-Professional Liaison.—Visits to county medical societies, the Upper Peninsula Medical Society and sundry specialty groups maintained intra-professional liaison. All requests for services by county medical societies or individual members were gladly received and carried out.

Motion Pictures.—The documentary film on the new MSMS Headquarters is progressing nicely. Several films prepared by the AMA and other recognizably authoritative organizations were purchased.

Science Fairs.—MSMS aided local medical society participation in science fairs and recognized the winner of the National Science Fair, Philip C. Bockman, from Grand Rapids.

Exhibits.—An educational exhibit was made at the Michigan State Fair and we point now to the fact that last year MSMS was awarded the trophy for having the outstanding exhibit at that fair. This fact occurred too late to include in last year's report. Again thanks are due the county societies, the Auxiliary, medical students and medical assistants for their cooperation.

Michigan Association of the Professions.—This organization has grown to a membership of 3,470 and has effectuated a program of service in the fields of education, public relations, legislation and business services. Of particular advantage to the medical profession were:

(a) The Congress of the Professions—Detroit, January 22-23, which held hearings on the subjects noted above and presented, among other outstanding speakers, Dr. Arthur S. Flemming, Secretary of Health, Education and Welfare and Dr. David B. Allman, Past President of the AMA.

(b) Day-long meetings to recruit students such as that held at Traverse City where students from a ten-county area were interviewed by eight deans of graduate schools.

(c) Legislative support of the Keogh Bill and opposition to the Forand Bill by letter and personal trip of officers to Washington, D. C.

(d) The instituting of Group Term and Major Medical Insurance programs, plus other business services such as the "new office" furnishing and equipping program.

Pamphlets.—Distribution of AMA pamphlets was emphasized this year in view of the excellence of these publications. Schools, school libraries, fairs, doctors' offices, etc., served as outlets for these. In addition, the MSMS "Emergency Medical Card" and the pamphlet "Your Family Health Record" were distributed in the number of several thousand.

Public Relations Workshop.—The annual County Secretaries-Public Relations Seminar was held in January, augmented by an Editor's Workshop for publishers of county society bulletins.

Mass Media.—By means of press releases to all Michigan newspapers, radio and TV stations, reports of current work of MSMS were carried to the general public. Also special stories were released to home-town papers

of doctors who received special honors. The work of the staff with the newspapers is a never-ending task highlighted by special work under the direction of the Press Committees at the Annual Session and the MCI.

Speakers Program.—Throughout the year, the medical profession served the schools, colleges, clubs, ancillary groups and business organizations with a steady flow of speakers on an unusually broad variety of subjects—uppermost, this year, were talks on the problems of the aged.

Publications.—Many legislative and other special bulletins were issued during the past year. Aid was given "The Auxilium," meeting announcements, JMSMS articles and a pronounced change in the format of THE JOURNAL was accomplished. A new "Medical Career Guide" was prepared by MSMS for publication by the Michigan Employment Security Commission. The special subcommittee in charge of this project was headed by J. M. Sheldon, M.D.

PR Library.—This growing repository of working materials continues to increase in value and usage. Adequate accommodations for it will be available shortly and it is anticipated that next year will see a vastly increased service emanating from this valuable facility.

Civic Affairs.—Increased interest in civic affairs has been evidenced by county societies during the past year. Delegations of doctors to Lansing, Washington, D. C., participation in aging conferences, regional health conferences, political parties, local "Homeramas," etc., have indicated an increasing interest by the profession in civic duty.

National Rural Health Conference.—Held in Michigan for the first time, this AMA-sponsored conference attracted nationwide interest and was well attended. MSMS played an active part in obtaining this conference for Michigan and aided in the development and presentation of the program. This program, plus the Regional Conferences, replaced the annual Michigan Rural Health Conference in 1960. The Annual Rural Health Conference series will be resumed in 1961.

Presidents Program.—The Presidents Program, to be reviewed elsewhere, is heartily endorsed as offering vast possibilities for outstanding public relations gains.

Comment: The concerted efforts of powerful opposing forces are making inroads in public thinking. The Public Relations Committee feels duty-bound to urge increased PR activity in the future, both on the part of the individual doctor and of his medical organizations.

COMMITTEES

Again, time and space preclude the listing in detail of the many activities of all the committees contributing to the splendid programs of the State Society. The accomplishments of the committees of the Society were achieved at the expense of countless hours of personal sacrifice on the part of their MD personnel. During 1960 a total of 110 meetings were held by our 82 committees. Practically every meeting was covered by your Secretary or Executive Director or one of the staff members. More than 600 Society members gave freely of their time to attend these meetings and assist in the operational activities of the State Society. Much commendation must be accorded the committee members who contributed so generously to develop and execute constructive programs—both scientific and economic—for the public welfare.

SERVICES FOR MEMBERS

1. *Group Health and Accident Insurance.*—Our carrier, Provident Life and Accident Insurance Company, advises that enrollment now stands at approximately 2,075. Plans are under way for an intensive drive to increase enrollment.

The number of new claims reported during the year was 239. Approximately 550 individual payments were made (in many instances periodic payments are necessary to discharge the Company's liability).

Actual claim payments to Insured Members during the year 1960 totalled $169,795.00. This includes the 10 per cent dividend payment on each Loss of Time claim, which was first originated on a year-to-year basis in November, 1959 and continued for another year in November, 1960.

In addition to the payments actually made, the reserve as of December 31, 1960, representing future liability on presently reported claims, totalled $50,837.70. As of that time there were 51 open claims.

2. *Group Life Insurance.*—Our group life insurance carrier, Mutual Benefit Life Insurance Company of New Jersey, reports that 1,396 MSMS members are now insured. The program was first offered March 1, 1959. Amount of life insurance in force is $11,900,000 and 22 death claims have been paid to date.

LEGAL AFFAIRS

The Regular Session of the 70th Michigan Legislature, one of the shortest in history, passed only 167 measures, fifty less than in any previous regular session.

The MSMS Legal Affairs Committee, however, found it necessary to carefully look into 122 proposals. Two important Senate Bills and two important House Bills, sponsored (or supported) by MSMS, were enacted into law. No legislation inimicable to the practice of medicine was passed.

Dominating the legislative scene, both in Washington and on Lansing Capitol Hill, was the subject of problems of the aging, particularly medical care. The State Legislature established both a Commission on Aging and a Legislative Advisory Council on Problems of the Aging. In Washington, the Forand Bill was sidetracked by the Kerr-Mills Bill to provide grants to states for medical care for aged individuals of low income. Kerr-Mills passed the Congress on September 13, and Michigan's Legislature went back into special session to become the first state to implement the new program.

While Michigan's Medical Aid to the Aged (MAA) program, enacted into law only three months ago, may become a model for other states wishing to implement the Federal legislation, proponents of the all-out Social Security approach have already introduced measures in the 1961 Congress to force through this new approach to socialized medicine.

The MSMS is deeply grateful to its members who participated in the Campaign For Freedom, for their unstinting aid in counselling their state and national legislators this past year.

NEW HEADQUARTERS

The new headquarters is rapidly nearing completion. Furnishings and equipment will be installed by mid-March; the staff has scheduled its move from 606 Townsend to the new address for early April. Formal dedication of the new building will be held on Sunday, June 4.

1960 HOUSE OF DELEGATES

In past years, the Secretary's Annual Report has contained a summary of actions of the House of Delegates. This year, your secretary omits this report because the Speaker's Summary already has appeared in THE JOURNAL of MSMS (November, 1960) and the entire proceedings will be published in Section No. 2 of the January number of THE JOURNAL.†

ACKNOWLEDGEMENT

Your Secretary is very grateful for the helpful cooperation given him by The Council.

Members of the Executive Office staff have been most helpful and cannot be too highly commended for their

†Published in the special House of Delegates Proceedings number of THE JOURNAL in January, 1961.

untiring efforts and loyalty to the Michigan State Medical Society.

To everyone who has aided so generously and willingly in the discharge of his duties, your Secretary is most grateful.

Respectfully submitted,
D. Bruce Wiley, M.D.
Secretary

TREASURER'S REPORT

December 1, 1959 to November 30, 1960

Pursuant to my appointment as Treasurer, by The Council, January, 1960, I am submitting the report of my office.

Balance on hand December 1, 1959	$15,003.56
Deposits 12-1-59 to 11-30-60	3,674.26
Total	$18,677.82
Withdrawal December 26, 1959 Sent to Mr. Roney for general account	$ 5,000.00
Withdrawal August 10, 1960 Sent to Mr. Roney for general account	13,000.00
Total Withdrawals	$18,000.00
Balance on hand November 30, 1960	$ 677.82

I am submitting a list of deposits and withdrawals during the past twelve months, also a list of securities at present in our portfolio in Lock Box 121 in Michigan National Bank, in Grand Rapids. The value of these securities amounted to $92,000.00 on November 30, 1960.

Respectfully submitted,
William A. Hyland, M.D.
Treasurer

List of Deposits and Withdrawals of Michigan State Medical Society in Treasurer's Account December 1, 1959 to November 30, 1960:

	Balance December 1, 1959	$15,003.56
Deposit	December 16, 1959	$ 696.93
	January 21, 1960	281.25
	January 27, 1960	55.20
	April 6, 1960	235.00
	May 17, 1960	312.50
	May 17, 1960	437.50
	May 24, 1960	75.00
	June 8, 1960	696.93
	June 20, 1960	281.25
	July 30, 1960	55.20
	September 30, 1960	110.00
	November 16, 1960	437.50
	Total Deposits	$ 3,674.26
		$18,677.82
Withdrawal	December 26, 1959	$ 5,000.00
Withdrawal	August 10, 1960	13,000.00
	Total Withdrawals	$18,000.00
	Balance November 30, 1960	$ 677.82

This statement has been certified by Mr. Frances P. Slattery, Vice President of Michigan National Bank, and the accounting firm of Mr. Kenneth B. Knostman of Lansing, Michigan.

List of securities belonging to Michigan State Medical Society in the safety deposit box of Dr. William A. Hyland, Treasurer of the Michigan State Medical Society:

4—$1,000 U. S. Savings Bonds No. M262323/4/5/6K dated July, 1954
$8,000 U. S. Treasury 2¾% bonds due 1975-80
Michigan National Bank, Lansing, safekeeping receipt for 4—$10,000 U. S. Savings Bonds No. X54843/846K dated June 18, 1954
$5,000 U. S. Savings Bond No. V49459K
Michigan National Bank, Grand Rapids, safekeeping receipt No. 4536 for $35,000 U. S. Treasury 2½% due November 15, 1961. (This above U. S. Treasury Bond was sold on December 8, 1960 and the proceeds around $35,000 were sent to Mr. Roney for the general fund account of new building. This is not part of the current report, but will be reported again next year—only noted at this time.)

We have turned into the general fund during the period of December 1, 1959 to November 30, 1960 a total of approximately $75,000.00 in U. S. bonds and Certificates of Deposit.

This statement has been certified by Mr. Frances P. Slattery, Vice President of Michigan National Bank, and the accounting firm of Mr. Kenneth B. Knostman of Lansing, Michigan.

REPORT OF KENNETH B. KNOSTMAN

Certified Public Accountant—1960

January 6, 1961

The Council
Michigan State Medical Society
Lansing, Michigan
Gentlemen:

The following comments relate to the scope of our examination of the MICHIGAN STATE MEDICAL SOCIETY, Lansing, Michigan, as at November 30, 1960 and to the more important items appearing in your financial statements for the fiscal year then ended.

HISTORY

The Michigan State Medical Society was organized on September 17, 1910 under the laws of the State of Michigan, as a non-profit corporation. The charter has been extended for a period of thirty years from September 17, 1940. The Society is affiliated with the American Medical Association, and it charters county medical societies within the State of Michigan. The purposes of the Society are the promotion of the science and art of medicine, the protection of the public health, and the betterment of the medical profession. In the furtherance of these purposes, the Society publishes The Journal of the Michigan State Medical Society.

COMMENTS

Your commercial bank account, maintained at the Michigan National Bank, Lansing, Michigan, was reconciled to your books of account, and further confirmed by direct correspondence with the bank as at November 30, 1960. Your savings account was closed on September 1, 1960.

Confirmation of the treasurer's account, as at November 30, 1960 was received from the Michigan National Bank, Grand Rapids, Michigan and reconciled to your books of account.

Petty cash in the Lansing office, in the amount of $82.30 was counted by our representative. The Detroit office petty cash of $50.00 was not verified.

Accounts receivable were confirmed by direct correspondence. Although not all confirmations have been returned, all reported differences have been reconciled to your accounts. An aging analysis of the accounts by month of charge is as follows:

September, October, November	$13,460.71
June, July, August	113.30
Over six months	185.52
TOTAL	$13,759.53

Included in the above total are individual accounts with credit balances totalling $3,687.41 which are the results of overpayments of accounts and prepayments for 1961 booth spaces.

The employees' share of insurance premiums, in an amount of $2,823.05, are reimbursed to the Society via payroll deductions. This balance is comprised of the following:

Retirement plan premiums	$2,771.36
Michigan Medical Service premiums	51.69
TOTAL	$2,823.05

The net cost of your retirement plan for the current year is as follows:

	Total	*Society Share*	*Employe Share*
Premium—1 year	$22,922.35	$11,461.18	$11,461.17
Adjustments	3,887.73	1,073.21	2,814.52
	$26,810.08	$12,534.39	$14,275.69
Less: Cancellations	2,054.63	1,027.32	1,027.31
NET	$24,755.45	$11,507.07	$13,248.38
Collections from employes	10,477.02		10,477.02
	$14,278.43		$ 2,771.36
Due from employes	$ 2,771.36		$ 2,771.36
NET SOCIETY COST	$11,507.07	$11,507.07	$ —0—

Employee travel advances were substantiated by non-interest bearing signed statements from the five employees to whom advances have been made.

The employee loan was being repaid through monthly payroll deduction. We were advised by your office that this loan was fully paid in December, 1960, upon termination of employment by the employee.

An analysis of your investments, showing changes during the current year, is set forth in Schedule 10, as well as a detail of interest received and amortization taken. All securities were confirmed by direct correspondence with the Michigan National Bank, Grand Rapids, Michigan, per their letter dated December 8, 1960.

Real estate owned, deposits, and payments on your new headquarters building currently under construction are set forth in Schedule 11, together with applicable depreciation allowances.

Prepaid expenses represent supplies purchased in 1960 that are applicable to 1961 activities.

Office equipment purchased during the period under review was charged to expense in accordance with the Society policy of not reflecting equipment as an asset.

Notes payable plus accrued interest represents three separate notes of $50,000.00, bearing interest at the rate of 5% per annum. Interest has been accrued thereon through November 30, 1960. The amounts of the individual notes was verified by direct correspondence with the payee.

State and federal unemployment taxes were computed by our representative as at November 30, 1960.

Unpaid invoices—general, were for current obligations incurred in the normal course of business.

Unpaid invoices—construction, were for billings of construction costs incurred by the contractor during the month of November, 1960.

Unpaid invoices—retainage, on new headquarters construction contract represents the amounts withheld from payment to the contractor and will become payable upon the satisfactory completion of the project.

Membership dues for year under review were reconciled to the 6,916 membership cards issued.

Income from the sale of booth space for the Michigan Clinical Institute and the Annual Session was verified by our representative and a test check of JOURNAL Advertising was in agreement with your books of account.

Net gain for all society functions for the year ended November 30, 1960 was $55,573.25 as set forth in Exhibit "C."

Respectfully submitted,
KENNETH B. KNOSTMAN
Certified Public Accountant

STATEMENT OF FINANCIAL CONDITION

November 30, 1960

ASSETS			
CASH ON HAND AND IN BANKS			
Michigan National Bank			
Lansing, Michigan (regular account)		$ 38,984.60	
Grand Rapids, Michigan (treasurer's account)		677.82	
Office cash (Lansing and Detroit, Michigan)		132.30	$ 39,794.72
ACCOUNTS RECEIVABLE			
Advertising, allowances and other items		13,759.53	
Due from employes—insurance premiums		2,823.05	
Employe travel advances		500.00	
Employe loan (interest rate at 4%)		4,078.04	$ 21,160.62
INVESTMENTS (Schedule 10)			$ 92,124.97
(Market or redemption value $90,381.00)			
PROPERTY AND EQUIPMENT			
Land—606 Townsend		$ 10,000.00	
Lot adjoining office		6,000.00	
Land—M-78 and Abbott Road		65,646.00	
Deposit on adjoining lot		500.00	
New headquarters building (under construction)		530,798.50	
Office building	$ 34,500.00		
Building improvements	5,664.06		
Building equipment	3,836.09		
Parking lot	1,913.60	$ 45,913.75	
		$658,858.25	
Less depreciation allowance		15,629.02	$643,229.23
OTHER ASSETS			
Prepaid expenses			$ 1,004.15
TOTAL ASSETS			$797,313.69

LIABILITIES

NOTES PAYABLE—BANK—plus accrued interest			$150,681.59
ACCOUNTS PAYABLE			
Federal unemployment tax		$ 218.08	
Michigan unemployment tax		42.15	
Withholding and social security tax		460.30	
Unpaid invoices:			
General		17,123.75	
Construction	$ 29,511.68		
Retainage on new headquarters construction contract	47,101.75	76,613.43	94,457.71
TOTAL LIABILITIES			$245,139.30
SOCIETY EQUITIES			
RESERVED FOR SPECIAL PURPOSES			
Public education reserve	$ 35,000.00		
Public education program	29,154.95	$ 64,154.95	
Public service account		2,985.15	
Professional relations account		(6,189.64)	
Rheumatic fever control program		1,436.22	
Building maintenance fund		(1,342.63)	
New headquarters fund		(31,737.25)	
New headquarters—under construction		454,185.07	
TOTAL RESERVED		$483,491.87	
GENERAL SOCIETY EQUITY—11-30-59	$178,506.71		
Less: Net loss for period (Exhibit B)	$(47,185.07)		
Fund transfers (Exhibit C)	(62,639.12)	(109,824.19)	68,682.52
TOTAL EQUITIES (Exhibit C)			$552,174.39
TOTAL LIABILITIES AND EQUITIES			$797,313.69

STATEMENT OF INCOME AND EXPENSES

Fiscal Year Ended November 30, 1960

INCOME			
Membership dues		$158,371.50	
Miscellaneous		95.31	
Interest income (Schedule 10)		4,719.39	
Amortization (Schedule 10)		257.96	$163,444.16
OTHER INCOME OR (LOSS)			
Annual session (Schedule 2)		(2,469.65)	
Michigan clinical institute (Schedule 3)		(210.98)	
"The Journal" (Schedule 4)		(11,574.83)	(14,255.46)
TOTAL INCOME			$149,188.70
EXPENSES			
Administrative and general		$ 97,592.99	
Society activity		46,368.96	
Committee expenses		52,411.82	
TOTAL EXPENSES (Schedule 1)			$196,373.77
NET LOSS			$(47,185.07)

EXPENSES

Fiscal Year Ended November 30, 1960

	Actual
ADMINISTRATIVE AND GENERAL	
Printing, mailing and postage	$ 8,704.23
Office supplies	4,316.78
Insurance and fidelity bonds	3,019.09
Auditing	905.00
Salaries—administrative and office (including legal counsel)	49,469.93
General counsel expense	4,167.32
Equipment and repairs	1,520.06
Telephone and telegraph	4,665.81
Taxes (other than property)	4,040.46
Miscellaneous expenses and contributions	3,757.16
Employes retirement trust	11,507.07
International Business Machines	1,520.08
TOTAL ADMINISTRATIVE AND GENERAL EXPENSES	$ 97,592.99
SOCIETY ACTIVITIES	
Council expense	$ 18,893.52
A.M.A. delegates and alternates	10,611.55
General society travel and entertainment	7,302.20
Officers' travel	3,731.15
Secretary's letters and office expense	1,458.17
Woman's auxiliary	600.00
Dues collection expense	3,772.37
TOTAL SOCIETY ACTIVITIES EXPENSE	$ 46,368.96
COMMITTEE EXPENSES	
Cancer Coordinating Committee	$ 1,032.29
Child Welfare Committee	161.94
National Defense	1,641.04
Geriatrics	1,140.17
Legislative	3,913.50
Maternal health	656.07
Mental health	651.09
Michigan Health Council	10,000.00
Post-graduate Medical Education	4,660.70
Preventive medicine	21.20
Permanent Conference Committee	71.17
Rural medical service	84.98
Scientific radio	1,260.45
Tuberculosis control	186.43
Venereal disease	81.01
Highway Accident Committee	136.68
Advisory Committee to Medical Assistants	755.34
Big Look Committee	438.71
Medical Care Insurance Committee	550.50
Michigan Joint Council on Aging Committee	28.77
Beaumont Memorial Restoration	5,206.22
Miscellaneous committee expense	1,102.34
Committee to Review Financial Status of Michigan State Medical Society	132.10
Malpractice Problems Study Committee	128.56
Blue Shield Committee	2,688.48
Relative Value Scale Committee	15,122.96
Committee on Committees	213.26
Constitution and By-laws Committee	67.73
Committee to Study Election and Status of Councilors	109.20
Permanent Advisory Committee on Fees	168.93
Committee to Study Michigan State Medical Society Publications	—0—
TOTAL COMMITTEE EXPENSES	$ 52,411.82
TOTAL EXPENSES	$196,373.77

INCOME AND EXPENSE OF THE ANNUAL SESSION

Fiscal Year Ended November 30, 1960

	Actual
INCOME	
Booth sales (95 spaces)	$25,945.00
TOTAL INCOME	25,945.00
EXPENSES	
Scientific meeting	3,366.13
Exhibit	4,341.88
Registration and hotel	1,156.18
State society and officers night	2,645.13
Promotion—printing, mailing, postage and scientific work committee	3,160.85
Press expense	2,259.58
Salaries	5,805.67
House of Delegates	4,576.14
Miscellaneous expenses	1,103.09
TOTAL EXPENSES	$28,414.65
GAIN OR (LOSS) ON ANNUAL SESSION	$(2,469.65)

INCOME AND EXPENSE OF THE MICHIGAN CLINICAL INSTITUTE

Fiscal Year Ended November 30, 1960

	Actual
INCOME	
Booth sales (72 spaces)	$14,040.00
TOTAL INCOME	14,040.00
EXPENSES	
Scientific meeting	2,578.57
Exhibit	4,813.39
Registration and hotel	1,362.24
Promotion—printing, mailing and postage	2,460.39
Press	1,173.02
Salaries	1,544.31
Residents and interns conference	253.07
Miscellaneous expense	65.99
TOTAL EXPENSE	$14,250.98
GAIN OR (LOSS) ON M.C.I.	$ (210.98)

INCOME AND EXPENSE SUMMARY

Fiscal Year Ended November 30, 1960

	Balance 12-1-59	*Fund Transfers*	*Income For The Period*	*Expenses For The Period*	*Net Gain or (Loss)*	*Balance 11-30-60*
Equity—general fund		$(62,639.12)	$163,444.16	$196,373.77	$(32,929.61)	
Annual session			25,945.00	28,414.65	(2,469.65)	$ 68,682.52
Michigan Clinical Institute	$178,506.71		14,040.00	14,250.98	(210.98)	
"The Journal"			135,073.74	146,648.57	(11,574.83)	
Contingent Fund	—0—	(8,733.61)	8,733.61	—0—	8,733.61	—0—
Building Maintenance Fund	4,936.60	—0—	—0—	6,279.23	(6,279.23)	(1,342.63)
Public Education Reserve	23,527.22	11,472.78	—0—	—0—	—0—	35,000.00
Public Education Program	19,651.34	15,000.00	54,265.41	59,761.80	(5,496.39)	29,154.95
Public Service	(8,683.54)	—0—	26,314.84	14,646.15	11,668.69	2,985.15
Professional Relations	(9,134.49)	0	36,529.37	33,584.52	2,944.85	(6,189.64)
Rheumatic Fever Control Program	3,275.12	0	2,180.67	4,019.57	(1,838.90)	1,436.22
Headquarters Fund	125,188.04	44,899.95	93,025.69	294,850.93*	93,025.69	(31,737.25)
New Headquarters—Under Construction	159,334.14	294,850.93	—0—	—0—	—0—	454,185.07
TOTAL	$496,601.14	$294,850.93	$559,552.49	$798,830.17	$ 55,573.25	$552,174.39

*NOTE: This item represents capital expenditures in your new headquarters building currently under construction. The balance in the "Headquarters Fund" represents amounts expended in excess of funds provided. The balance in "New Headquarters-Under Construction" represents your cash investment in your new building as at November 30, 1960.

INCOME AND EXPENSE OF "THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY"

Fiscal Year Ended November 30, 1960

	Actual
INCOME	
Allocations from dues	$ 8,733.62
Subscriptions—non members	922.75
Advertising sales	120,811.86
Reprint and cut sales	4,605.51
TOTAL INCOME	$135,073.74
EXPENSES	
Editors expense	$ 3,102.33
Printing, mailing and postage	89,691.04
Reprint and cut expense	3,314.52
Salaries	23,623.46
Discounts and commissions	26,791.72
Miscellaneous expense	125.50
TOTAL EXPENSES	$146,648.57
GAIN OR (LOSS) ON "THE JOURNAL"	$(11,574.83)

INCOME AND EXPENSE OF THE BUILDING MAINTENANCE FUND

Fiscal Year Ended November 30, 1960

	Actual
INCOME	
Allocation from dues	—0—
EXPENSES	
Maintenance—utilities, decorating, supplies, yard work, etc.	$ 1,945.75
Salaries—janitor	1,202.76
Property taxes	1,029.03
Insurance—fire and liability	1,785.85
Depreciation	1,785.85
TOTAL EXPENSES	$ 6,279.23
GAIN OR (LOSS) ON BUILDING MAINTENANCE FUND	$ (6,279.23)

INCOME AND EXPENSE OF THE PUBLIC EDUCATION PROGRAM

Fiscal Year Ended November 30, 1960

	Actual
INCOME	
Allocation from dues	$ 54,072.66
Other income	192.75
TOTAL INCOME	$ 54,265.41
EXPENSES	
Committee meetings	$ 129.35
Equipment and repairs	1,022.78
Printing, mailing and postage	3,738.21
Office supplies	1,939.22
Salaries	25,742.67
Telephone and telegraph	1,199.52
Travel and entertainment	4,222.09
Exhibit expense	2,202.04
Publications, pamphlets, clippings	643.76
Radio, television and cinema	1,007.82
Miscellaneous expense	346.88
Library	370.70
Michigan Association of Professions	2,502.10
Campaign for Freedom	14,694.66
TOTAL EXPENSES	$ 59,761.80
GAIN OR (LOSS) DURING PERIOD	$ (5,496.39)

INCOME AND EXPENSE OF THE PUBLIC SERVICE ACCOUNT

Fiscal Year Ended November 30, 1960

	Actual
INCOME	
Allocation from dues	$ 26,314.84
TOTAL INCOME	$ 26,314.84
EXPENSES	
Salaries	$ 12,472.57
Telephone and telegraph	580.16
Travel and entertainment	1,593.42
TOTAL EXPENSES	$ 14,646.15
GAIN OR (LOSS) DURING PERIOD	$ 11,668.69

INCOME AND EXPENSE OF THE PROFESSIONAL RELATIONS ACCOUNT

Fiscal Year Ended November 30, 1960

	Actual
INCOME	
Allocation from dues	$ 36,529.37
TOTAL INCOME	$ 36,529.37
EXPENSES	
Rent to Wayne County Medical Society	$ 2,494.55
Salaries	17,387.29
Telephone and telegraph	810.72
Travel and entertainment	2,215.75
National meeting expense	2,287.08
County secretary's—Public Relations Conference	6,719.63
Woman's auxiliary	1,537.80
Miscellaneous expenses	15.00
Committee meetings	116.70
TOTAL EXPENSES	$ 33,584.52
GAIN OR (LOSS) DURING PERIOD	$ 2,944.85

INCOME AND EXPENSE OF THE RHEUMATIC FEVER CONTROL PROGRAM

Fiscal Year Ended November 30, 1960

	Actual
INCOME	
Grant from Michigan Heart Association	$ 2,180.67
TOTAL INCOME	$ 2,180.67
EXPENSES	
Committee meetings	$ 257.87
Printing, mailing and postage	52.00
TOTAL CENTRAL OFFICE EXPENSES	$ 309.87
CONTROL CENTERS	
Alpena	$ —0—
Ann Arbor	612.50
Bay City	60.00
Detroit	145.00
Grand Rapids	1,662.20
Kalamazoo	1,230.00
Saginaw	—0—
Traverse City	—0—
TOTAL CONTROL CENTERS	$ 3,709.70
TOTAL EXPENSE	$ 4,019.57
GAIN OR (LOSS) DURING PERIOD	$ (1,838.90)

SECURITIES OWNED

November 30, 1960

	Maturity Date	Face Value 11-30-60	Cost (Book Value) 12-1-59	Redemption or Market Value 11-30-60	Purchases During Period	Sales or Repemptions During Period	Amortization Debit or (Credit)	Cost (Book Value) 11-30-60	Interest Received to Last Interest Date
UNITED STATES GOVERNMENT SECURITIES									
Savings Bonds—series "G"	3- 1-60		$ 5,000.00		$	$ 5,000.00	$	$ —0—	$ 62.50
Treasury Bond—series "B" 2¾%	4- 1-80/75	$ 8,000.00	8,133.89	$ 8,000.00			(8.92)	8,124.97	220.00
Savings Bonds—series "K" 2.76%	6- 1-66	45,000.00	45,000.00	43,605.00				45,000.00	1,242.00
Savings Bonds—series "K" 2.76%	7- 1-66	4,000.00	4,000.00	3,876.00				4,000.00	110.40
Treasury Bond 2¼%	6-15-62/59		25,000.00			25,000.00			562.50
Treasury Bond 2½%	3-15-70/65		9,867.18			9,867.18			253.45
Treasury Bond 2½%	11-15-61		24,832.80			24,832.80			604.03
Treasury Bond 2½%	11-15-61	35,000.00	34,733.12	34,900.00			266.88	35,000.00	875.00
Savings deposit receipt—Michigan National Bank—10-24-57	Demand		5,000.00			5,000.00			165.87
Savings deposit receipt—Michigan National Bank—5-28-58	Demand		5,062.50			5,062.50			151.86
TOTAL SECURITIES		$ 92,000.00	$166,629.49	$ 90,381.00	$ —0—	$74,762.48	$257.96	$92,124.97	$4,247.61
Interest on savings account									299.37
Interest on loan									172.41
TOTAL INTEREST EARNED									$4,719.39

PROPERTY AND DEPRECIATION ALLOWANCES

November 30, 1960

	Date Acquired	Cost	Depreciation Allowance Prior Years	Remaining Cost	Estimated Life	1960 Depreciation Expense	11-30-60 Depreciation Allowance
Land—606 Townsend	1951	$ 10,000.00	$ —0—	$ 10,000.00		$ —0—	$ —0—
Adjoining lot	1952	6,000.00	—0—	6,000.00		—0—	—0—
Building—606 Townsend	1951	34,500.00	9,554.00	24,946.00	30	1,150.00	10,704.00
		50,500.00	9,554.00	40,946.00		1,150.00	10,704.00
BUILDING IMPROVEMENTS—606 Townsend							
New building entrance	1953	3,917.85	837.90	3,079.95	30	130.55	968.45
Remodel basement and storeroom	1956	1,746.21	198.87	1,547.34	30	58.21	257.08
		5,664.06	1,036.77	4,627.29		188.76	1,225.53
BUILDING EQUIPMENT—606 Townsend							
Lighting	1952	2,121.50	1,119.71	1,001.79	15	141.43	1,261.14
Boiler	1952	1,714.59	904.76	809.83	15	114.30	1,019.06
		3,836.09	2,024.47	1,811.62		255.73	2,280.20
PARKING LOT—606 Townsend	1953	1,913.60	1,227.93	685.67	10	191.36	1,419.29
OTHER REAL ESTATE AND DEPOSITS							
Land—M-78 and Abbott Road	8–19–58	65,646.00	—0—	65,646.00		—0—	—0—
Deposit on adjoining lot	7–24–58	500.00	—0—	500.00		—0—	—0—
New headquarters building (under construction)	1959-1960	530,798.50	—0—	530,798.50		—0—	—0—
Paid items $454,185.07							
Unpaid items 76,613.43							
$530,798.50		596,944.50	—0—	596,944.50		—0—	—0—
TOTALS		$658,858.25	$ 13,843.17	$645,015.08		$ 1,785.85	$ 15,629.02

MSMS 1961 BUDGET

RECAPITULATION

INCOME:

Membership Dues: $75.00	$431,250.00	
Less: THE JOURNAL @ $3.00	17,250.00	
Public Education @ $9.25	53,187.50	
Public Service @ $4.50	25,875.00	
Professional Relations @ $6.25	35,937.50	
Hdqts. Fund @ $15.00	86,250.00	
Beaumont Foundation $1.00	5,750.00	
Balance to General Fund @ $36.00		$207,000.00
Interest and Miscellaneous Income		1,500.00
TOTAL GENERAL FUNDS AVAILABLE		$208,500.00

EXPENSES:

Administrative and General	$113,222.00	
Society Activities	41,800.00	
Committee Expenses	36,400.00	191,422.00
Estimated Gain in 1961 (General Fund)		$ 17,078.00

Account	Estimated Income	Estimated Expense	Estimated Balance
General Fund	$208,500.00	$191,422.00	$ 17,078.00
Annual Session	32,000.00	32,000.00	—0—
Michigan Clinical Institute	13,395.00	13,395.00	—0—
THE JOURNAL	132,850.00	127,100.00	5,750.00
Public Education	54,337.50	55,250.00	—912.50
Public Service	25,875.00	24,200.00	1,675.00
Professional Relations	35,937.50	35,310.00	627.50
TOTAL (Exclusive of Hdqts.)	$502,895.00	$478,677.00	$ 24,218.00
New Headquarters	225,891.07	255,891.07	—0—
Building Maintenance (Incl. "606")	53,441.82	47,750.00	5,691.82
	$279,332.89	$273,641.07	$ 5,691.82
GRAND TOTAL:	$782,227.89	$752,318.07	$ 29,909.82

1961 BUDGET

GENERAL FUND

ACCOUNT TITLE	1961
INCOME:	
5750 Members @ $75.00	$431,250.00
Less: $3.00 to THE JOURNAL	17,250.00
9.25 to Public Education	53,187.50
4.50 to Public Service	25,875.00
6.25 to Professional Relations	35,937.50
15.00 to New Headquarters	86,250.00
1.00 to Beaumont Foundation	5,750.00
Balance to General Fund @ $36.00	207,000.00
Interest and Miscellaneous Income	1,500.00
TOTAL FUNDS AVAILABLE	$208,500.00
EXPENSES: (Administrative and General)	
Printing, Mailing and Postage	$ 10,372.00
Office Supplies	5,000.00
Insurance and Fidelity Bonds	4,000.00
Auditing	900.00
Salaries—Administrative and Office (Includes Legal Counsel)	55,750.00
General Counsel Expense (Includes $3,600 office expense)	4,100.00
Equipment and Repairs	6,000.00
Telephone and Telegraph	6,500.00
Taxes (Other than property)	4,000.00
Miscellaneous Expense and Contributions	4,000.00
Employe's Retirement Trust	11,000.00
I.B.M.	1,600.00
TOTAL ADMINISTRATIVE & GENERAL EXPENSE	$113,222.00
EXPENSES: (Society Activities)	
Council Expense	$ 18,000.00
AMA Delegates and Alternates	8,500.00
General Society Travel and Expense	6,000.00
Officers Travel	3,500.00
Secretary's Letters and Office Expense	1,500.00
Woman's Auxiliary	600.00
Dues Collection Expense	3,700.00
TOTAL SOCIETY ACTIVITY EXPENSE	$ 41,800.00
EXPENSES: (Committees)	
Cancer Coordinating Committee	$ 1,000.00
Child Welfare	150.00
Disaster Medical Care	750.00
Geriatrics	1,200.00
Industrial Health	100.00
Iodized Salt	100.00
Legal Affairs	4,000.00
Maternal Health	500.00
Mental Health	500.00
Michigan Health Council	10,000.00
Postgraduate Medical Education	4,500.00
Preventive Medicine	100.00
Permanent Conference Committee	100.00
Rural Medical Service	100.00
Scientific Radio	1,400.00
Tuberculosis Control	200.00
Venereal Disease	100.00
Highway Accident Committee	150.00
Advisory Committee to Medical Assistants	400.00
Big Look Committee	300.00
Medical Care Insurance Committee	7,500.00
Relative Value Study Committee	1,500.00
Michigan Joint Council on Aging	100.00
Miscellaneous Committees	1,200.00
House of Delegates Committees:	
Special Committee to Review Constitution and Bylaws	100.00
Committee to Study Problem of Malpractice	100.00
Permanent Advisory Committee on Fees	150.00
Committee to Study Indigent Doctors	100.00
TOTAL COMMITTEE EXPENSE	$ 36,400.00

BUILDING MAINTENANCE FUND AND DEBT RETIREMENT (INCL. "606")

INCOME:	
From New MSMS Headquarters Fund	$ 53,441.82
EXPENSES:	
Maintenance (Utilities, Supplies)	10,000.00
Salaries—Custodial	4,500.00
Property Taxes	14,000.00
Insurance—Fire and Liability	3,500.00
Depreciation	12,000.00
Building Equipment	2,000.00
Grounds Keeping	1,750.00
TOTAL BUILDING MAINTENANCE	$ 47,750.00
GAIN OR LOSS FOR THE YEAR (G)	5,691.82
BALANCE FROM PRIOR YEARS (L)	1,342.63
BALANCE TO FUTURE YEARS (G)	4,349.19

NEW HEADQUARTERS FUND

INCOME:	
Allocation from Membership Dues	$ 86,250.00
Contributions	—0—
Fund Transfers and Sale of Bonds	—0—
From Borrowing	50,000.00
Balance from Prior Years	89,641.07
TOTAL FUNDS AVAILABLE	$225,891.07
EXPENSES:	
Expenditures (To Headquarters Equity)	$172,449.25
BALANCE TO BUILDING MAINTENANCE FUND	53,441.82
Estimated Cost of New Headquarters (From 1960 House of Delegates Report)	$722,292.00
Less: Land already purchased	—66,146.00
Less: Equity Acquired 1959-1960	—483,696.75
Estimated Balance to be Completed 1961	$172,449.25

ANNUAL SESSION

INCOME:	
Booth Sales 125 Spaces (Gr. Rapids)	$ 32,000.00
EXPENSES:	
Scientific Meeting	7,300.00
Exhibit	5,100.00
Registration and Hotel	1,300.00
State Society and Officers' Night	2,500.00
Promotion: Printing, Mailing and Postage and Scientific Work Committee	3,000.00
Press Expense	2,000.00
Salaries	5,600.00
House of Delegates Expense (Includes Special Guests)	4,500.00
Miscellaneous Expenses	700.00
TOTAL ANNUAL SESSION EXPENSE	$ 32,000.00

MICHIGAN CLINICAL INSTITUTE

INCOME:	
Booth Sales 70 spaces	$ 13,395.00
EXPENSES:	
Scientific Meeting	3,250.00
Exhibit	4,800.00
Registration and Hotel	650.00
Promotion—Printing, Mailing and Postage	2,000.00
Press Expense	1,000.00
Salaries	1,300.00
Residents and Interns Conference	250.00
Miscellaneous Expense	145.00
TOTAL MCI EXPENSES	$ 13,395.00

THE JOURNAL

INCOME:	
Allocation from Dues	$ 17,250.00
Subscriptions—Non-members	900.00
Advertising Sales	110,000.00
Reprint and Cut Sales	4,700.00
TOTAL JOURNAL INCOME	$132,850.00
EXPENSES:	
Editor's Expense	3,000.00
Printing, Mailing and Postage	80,000.00
Reprint and Cut Expense	3,300.00
Salaries	16,700.00
Discounts and Commissions, Advertisement Sales	24,000.00
Miscellaneous Expenses	100.00
TOTAL JOURNAL EXPENSES	$127,100.00
GAIN OR LOSS FOR THE YEAR (G)	5,750.00

PUBLIC EDUCATION RESERVE

INCOME:	
Allocation from Membership Dues	—0—
Balance from Prior Years	$ 35,000.00
TOTAL PUBLIC EDUCATION RESERVE	$ 35,000.00

PUBLIC EDUCATION ACCOUNT

INCOME:	
Allocation from Membership Dues	$ 53,187.50
Other Income	150.00
From P.E. Reserve (Auth. by Council)	1,000.00
TOTAL PUBLIC EDUCATION INCOME	$ 54,337.50
EXPENSE:	
Committee Meetings	$ 200.00
Equipment and Repairs	5,000.00
Printing, Mailing and Postage	4,000.00
Office Supplies	2,200.00
Salaries	27,500.00
Telephone and Telegraph	1,500.00
Travel and Expenses	5,000.00
Exhibit Expense	2,800.00
Publications, Pamphlets, Clippings	1,500.00
Radio, TV and Cinema	3,000.00
Miscellaneous Expenses	500.00
Library	500.00
Michigan Association of Professions	550.00
Campaign for Freedom	1,000.00
TOTAL PUBLIC EDUCATION EXPENSE	$ 55,250.00
GAIN OR LOSS FOR THE YEAR (L)	912.50

PUBLIC SERVICE ACCOUNT

INCOME:	
Allocation from Membership Dues	$ 25,875.00
EXPENSES:	
Salaries	$ 13,700.00
Telephone and Telegraph	2,000.00
Travel and Expenses	3,000.00
Rural Health Conference	500.00
Miscellaneous Meetings	2,000.00
New Headquarters Dedication	3,000.00
TOTAL PUBLIC SERVICE EXPENSE	$ 24,200.00
GAIN OR LOSS FOR THE YEAR (G)	1,675.00

PROFESSIONAL RELATIONS ACCOUNT

INCOME:	
Allocation from Membership Dues	$ 35,937.50
EXPENSES:	
Salaries	$ 18,700.00
Telephone and Telegraph	1,000.00
Travel and Expenses	3,000.00
Rent to Wayne County Medical Society	3,510.00
National Meeting Expense	2,000.00
County Secretary's—P.R. Conference	4,000.00
Woman's Auxiliary and Bulletin	1,600.00
Printing, Mailing and Postage	1,500.00
TOTAL PROFESSIONAL RELATIONS EXPENSE	$ 35,310.00
GAIN OR LOSS FOR THE YEAR (G)	627.50

Ingham Offers Spring Clinic

Seven scientific speakers plus a prominent California attorney will make presentations at the annual Spring Clinic of the Ingham County Medical Society at the Jack Tar Hotel, Lansing, April 6.

The program for the day-long meeting, formerly known as the May Clinic, will begin at 9:00 a.m. and conclude at 5:30 p.m. Arrangements are under the direction of David Siegel, M.D., and Jerome Cordes, M.D.

The lead-off speaker will be Robert L. Egan, M.D., University of Texas, on "Soft Tissue Roentgenography of the Breast." Alexander Brunschwig, M.D., Cornell University Medical College, will discuss "The Surgical Treatment of Cancer of the Cervix Including the Problem of Post Radiation Recurrences," and Wolf W. Zuelzer, M.D., Detroit, will speak on "Pediatrics."

Melvin M. Belli, attorney with law offices in Rome, Tokyo and San Francisco, will speak at the subscription luncheon on the legal aspects of medical practice.

The afternoon program beginning at 2:15 p.m., features four scientific speakers: Douglas M. Haynes, M.D., University of Louisville School of Medicine, on "Cesarean Section: Indications and Contraindications;" Isidore Snapper, M.D., Beth-El Hospital, Brooklyn, on "Diagnostic Clues;" George E. Moore, M.D., Roswell Park Memorial Institute, Buffalo, on "Cancer Chemotherapy: Implications for Physicians and Surgeons," and R. G. Bunge, M.D., University of Iowa College of Medicine, on "Sex Determination."

Refilling Prescriptions

Dear Doctor:

I have your inquiry, which is phrased as follows:

"Who would be liable should anything go wrong when a druggist refills a prescription without a doctor's knowledge or consent? This has happened twice recently with me and with medicines that we are cautioned to follow closely."

In considering the possible liability of the physician arising out of the refilling of prescriptions, it is all important, of course, to consider the nature of the prescription involved. I believe it safe to say that physicians' prescriptions generally fall into one of three classes.

First, those in which drugs are prescribed which cannot be legally dispensed by the pharmacist except upon a physician's prescription (notably narcotics for example). Here the pharmacist is prevented by law from refilling such prescription and if he does so in violation of the law, the physician cannot be held responsible.

Second, those, at the opposite extreme, in which drugs or medicines of a known harmless nature are prescribed and in relation to which there could be no reasonable expectation of harm resulting from continued use or refilling of the prescription. Ordinarily the drugs prescribed in this type of prescriptions are such as may be dispensed by the pharmacist without prescription and there is, therefore, little likelihood of trouble following.

Third, those in which drugs are prescribed which are of such nature that their continued use or use under conditions uncontrolled or unsupervised by the physician may be dangerous, but which, nevertheless, may be legally (if not ethically) dispensed by the druggist without a new prescription.

In issuing this type of prescription, I think the physician would be well advised to note upon it by appropriate language that the prescription is not to be refilled. I do not say categorically that a physician would become liable if he fails to do this but I can see definite possibilities of liability under certain circumstances if he fails to do so.

It is well grounded in the law that the physician has a duty to warn his patient of the dangers involved in the use of certain drugs or treatments and while this duty would ordinarily be complied with by direct warnings or instructions to his patient, it seems to me that the doctor is in a much better position to defend against a claimed breach of duty in this respect if he marks prescriptions "unrefillable" when such is indicated.

Sincerely yours,
LESTER P. DODD
Legal Counsel



MICHIGAN DEPARTMENT OF HEALTH

ALBERT E. HEUSTIS M.D., State Health Commissioner

Public Health and the "Presidents Program"

Public health services are among the ingredients in the MSMS "Presidents Program" to add five more good years to the lifetimes of Michigan people in the next five years. The public health contribution toward this admirable goal could be increased by strengthening the following services in 1961-62:

1. *Local Health Departments*—Improved financial support is needed for local health department services. In the past ten years, mounting demands have been made of local health departments but state financial aid actually has decreased from $320,000 to $315,000. In addition, approved local health departments should be established in the 14 counties still without them. They are: Berrien, Cass, Clinton, Gogebic, Gratiot, Huron, Ionia, Jackson, Lapeer, Livingston, Marquette, Montcalm, Tuscola, and Van Buren. The time has passed when any part of Michigan should be without the services of a well-organized, well-financed, and adequately staffed local health department.

2. *Early Detection of Diseases* — School vision screening programs currently reach only about one out of four children who should be tested and the hearing conservation program currently screens only one in three youngsters who should be checked. With an estimated 300,000 school children handicapped by an undiscovered vision defect and about 50,000 with some degree of hearing loss, cooperative screening efforts should be expanded. In addition, there is rapidly growing medical endorsement of screening programs for cervical cancer, which killed nearly 1,900 Michigan women in the past five years; for diabetes, which caused over 1,700 deaths last year; and for glaucoma, the second cause of blindness. Physicians, local health departments, voluntary agencies and the state health department have jointly developed highly successful projects to screen adults for these diseases. This effort should be rapidly expanded.

3. *Tuberculosis Care*—Use of newer medicines and surgery has reduced the average tuberculosis hospitalization period from two years in 1950 to ten months today. But with the reduced time in the hospital, home nursing and clinical follow-up of the patient becomes correspondingly more important. Without close follow-up supervision, the patient may not continue therapy which is needed to complete his recovery, or may have a resurgence of the disease. Local health departments need increased support for their work with physicians to provide the essential follow-up services for 3,500 TB patients home from the hospital.

4. *Home Nursing Services*—While about three out of four Michigan people live in areas served by some type of home nursing services, this service is available to all of the residents of only 13 counties and to part of the residents of 10 additional counties. Very little home bedside nursing help is available in 60 counties of the state. Such services should be developed as rapidly as possible in the coming year to assist physicians in the care of patients with long-term illness; to take the pressure from overloaded hospitals; and to save money for patients, welfare agencies, and taxpayers.

5. *Food Sanitation*—Michigan's program to safeguard milk, meat, and other foods should be streamlined with emphasis on protecting the health of the consumer.

6. *Tooth Decay*—With Michigan people spending $75,000,000 annually on tooth decay, increased work is needed to encourage more communities to adjust the fluoride content of their water supplies. At present, while it has been proved that one part fluoride to one million parts of water will reduce tooth decay in children by about two-thirds, only one out of six Michigan people served by public water supplies has the benefits of fluoridation. Among other dental health needs is the lack of adequate dental care services for the old and needy, including patients in nursing homes and homes for the aged.

7. *Air Pollution*—With increasing evidence pointing to air pollution as a contributing factor in serious respiratory diseases, state legislation is needed to establish public health responsibility in this field.

Strengthening these public health services next year could help the MSMS Presidents Program "gain maximum benefit from the monumental gains of modern medical research. . . ."

ifferent approach to birth control

emko®

VAGINAL FOAM

PATS. PEND.

ACTIVE INGREDIENTS:
Nonyl phenoxy polyoxyethylene ethanol 8.0%
Benzethonium Chloride 0.2%

USING PRINCIPLES NEVER BEFORE APPLIED TO CONTRACEPTIVES

THE FIRST AEROSOL FOAM!

The volume of the material is expanded ten times to create a BLOCK OF FOAM.

THIS BLOCK SEALS THE CERVICAL OS.

Only a FOAM can successfully serve this diaphragm-like function . . . without interfering with normal intercourse or reducing sensory contact.

A HIGHLY EFFECTIVE SPERMICIDE

quickly renders the trapped sperm immotile.

EASIER TO USE THAN ANY OTHER EFFECTIVE CONTRACEPTIVE

The foam is placed with an entirely new type of "Touch Control" applicator. It's filled automatically by touching the open end to the top of the bottle.

- **No douching . . . it vanishes after use**
- **Absolutely no greasiness or "after-mess"**
- **No diaphragm . . . the foam does the blocking**
- **No irritation for husband or wife**



MARGARET SANGER RESEARCH BUREAU

INTERIM REPORT

In the Contraception Service of the Margaret Sanger Research Bureau, through October 31, 1960, Emko had been used from one to 22 months by 362 patients, with a total of 12 unplanned pregnancies. Seven of the pregnant patients admitted irregularity in the use of Emko.

Two planned pregnancies had also occurred after stopping the use of Emko.

A. J. SOBRERO, M.D. *Research Director*

EDITORIAL OPINION

An Ominous Coincidence

Battle Creek Enquirer and News, January 12, 1961

It was coincidence, of course, but the ominous effect of two developments in the matter of medical care coming on the same day cannot be ignored.

In Lansing, the Michigan Hospital Service asked for a 22.04 per cent rate increase and the Michigan Medical Service requested a 13.5 per cent raise. The proposed increases would cost the average family about $2.54 per month.

At the same time, President-elect Kennedy received a recommendation for a $1.4 billion federal-sponsored medical care program which would give help to those who generally need it the most—the aged. It is quite clear that if such a program is started, expansion is inevitable. Future years could well bring the condition which most medical men—and millions of other Americans—fear: socialized medicine.

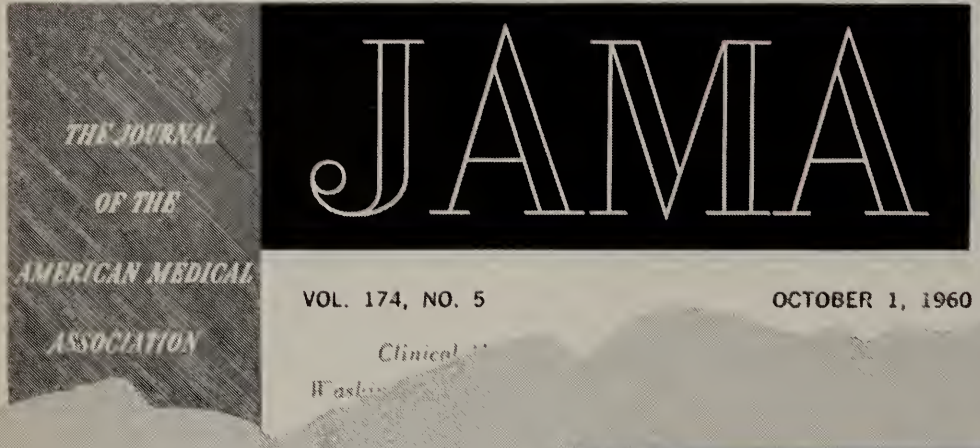
Right now, there may be enough sentiment against federal medical care plans to either defeat them or to curtail their scope in Congress. But, one may be certain that if private insurance companies, such as the Michigan group, continue to ask and get rate increases, that opposition will crumble quickly.

The people simply will try to shift their burden to the government regardless of the fact that in the long run, they will pay for it anyway.

No one will deny that the Michigan groups must have more money if they are to continue operations as usual. But, therein may lie the problem. Is it necessary to continue operations as usual? Is it possible that the entire structure of Michigan Blue Cross and Blue Shield needs an overhaul? Is it possible, for example, that a more careful screening of patients, particularly the ones who are in hospitals repeatedly, is needed?

The Michigan medical care group seems to be heading for its own destruction unless the right answers can be found.

Constant rate increases by Michigan Blue Cross and Blue Shield are bound to impel people to look elsewhere for medical care insurance at lower premiums. And, they can be found in many large insurance companies. If there is a mass exodus of policy



newest
J.A.M.A.
paper[1]
reports

DBI

"oral therapy of choice"
in management of diabetes . . . from the
mild stable adult to the severe labile juvenile

holders from the Michigan group, the problem will be intensified further by the decline in operating funds.

When the Blue Cross-Blue Shield proposal is taken up in Lansing at a public hearing next month, a public furor may be expected. This would be the appropriate time for state Insurance Commissioner Blackford to delve into all of the problems besetting the Michigan group.

The people need Michigan Blue Cross and Blue Shield, but that need is mutual. Without subscribers, the companies cannot operate. But, a never-ending tide of rate increases can drive those subscribers to join other medical care plans or to do even worse—enthusiastically embrace a gigantic federal program.

Mirror, Mirror on the Wall

Detroit Medical News, December 12, 1960

Much newsprint has been consumed of late by both favorable and unfavorable comment about "the public image of the doctor." This observer is goaded into active challenge against the laments of public relation counselors and marketing research directors who invent nostrums for brightening medicine's tarnished halo. Once calmed, however, I become more than a little concerned by the multiplicity of the complaints against us as physicians. Allow me, then, one more exhortation.

Many of us have been disconcerted by having a patient tell us, "I like you personally, Doctor, but I don't care for the things organized medicine stands for." The viewpoint of most laymen is that our county, state and national associations are against most measures which would improve medical care. Our pronounced stands against hospital insurance, medical fee insurance and Social Security extension to care for the aging are misinterpreted. Our anxiety based on what has happened elsewhere to the quality of medical care under socialism is translated as greed and money mindedness.

We as individual physicians can bask in the personal knowledge of many grateful patients who after being brought back to health from serious illness are thankful. It is the "other fellow" which the public survey is chastizing. This attack on medicine in general raises our hackles to challenge but we do not take it as a personal problem. This is the first and greatest mistake!

It should not be implied that we do not owe the press a great debt in the proper reporting of medical progress which supplies a backdrop of dedication for our public image. Television drama adds to this allure

results of 104 "problem" diabetics treated with...

fair to excellent control in 91 of 104 diabetics (88%)
...achieved with DBI use alone or combined with exogenous insulin.

"more useful and certainly more serene lives"...
In many diabetics "phenformin (DBI) has been responsible for adjusting life situations so that patients whose livelihood was threatened, whose peace of mind was disturbed because of lability of their diseases, have been restored to more useful and certainly more serene lives."

"no evidence of toxicity" due to DBI...
a relatively low incidence of gastrointestinal reactions... were found in this series.

DBI®

DBI (brand of Phenformin HCl-N[1]—β-phenethylbiguanide HCl) is available as 25 mg. white, scored tablets, bottles of 100 and 1000.

Rely on DBI, alone or with insulin, to enable a maximum number of diabetics to enjoy continued convenience and comfort of oral therapy in the satisfactory regulation of...

stable adult diabetes • sulfonylurea failures unstable (brittle) diabetes

1. Barclay, P. L.: J.A.M.A. 174:474, Oct. 1, 1960.

NOTE — before prescribing DBI the physician should be thoroughly familiar with general directions for its use, indications, dosage, possible side effects, precautions and contraindications, etc. Write for complete detailed literature.

u. s. vitamin & pharmaceutical corporation
Arlington-Funk Laboratories, division • 250 East 43rd Street, New York 17, N.Y.

The most significant advance in analgesics since the isolation of morphine in 1805

Remarkable effectiveness and greater freedom from side reactions in the widest range of clinical applications

FOR PAIN

NUMORPHAN®

BRAND OF OXYMORPHONE, ENDO

A NEW ERA IN PAIN RELIEF

clinically tested for 5 years/evaluated in 120 U. S. hospitals/over a quarter of a million doses given/ more than 25,000 patients treated

SUPPLIED:

Vials: 10 cc., singly and in boxes of three.
Ampuls: 1 cc. and 2 cc., in boxes of 12 and 100.
(Each cc. of NUMORPHAN* contains 1.5 mg. oxymorphone as the hydrochloride.)
Suppositories: 2 mg. and 5 mg., in boxes of 6.

THE G. A. INGRAM COMPANY
4444 Woodward Avenue, Detroit 1, Mich.

*U. S. Pat. 2,806,033.

by fairy-tale romances. These growing pictures may be less than pretty in the house organs of other agencies however, that wish to discredit medicine for selfish purposes.

The hard fact, however, is that with all of these multiple approaches of communication too often our objective manner to socio-economic problems is interpreted as reactionary. Our remoteness and lack of personal involvement with our patients has contributed to our unfavorable reflection in the public eye. It is not the "other fellow" all of the time at whom the survey is pointing the finger! It is not the job of *only* your county, state or national society to redefine the medical brand image to which the public will react. It must also be an individual endeavor to convince those "other people" that medicine really stands for something.

Collectively, we are for measures that will insure the public better health care. Individually, we must convince the public of this. Don't let John do it! We cannot delegate our public relations to any receptionist or psychologist. Each of us has an image. What you do in your relations with your patients, but *more especially with my patients* has more to do with what the public thinks of us than anything else. The resultant representation will play a key role in the future course of political and public behavior involving the medical profession.

DONALD N. SWEENY, JR.

Hail—But Heartily

Oakland County Medical Society Bulletin,
Vol. XXXV, No. 2

I am distressed and chagrined by the paucity of my acquaintance with the membership of the society. I believe I have been as active in hospital staff and committee society activities as the average physician. I suspect I have attended society functions as often, and certainly somewhat longer, than the average member.

Despite this, I can not claim to recognize by name and face, nor to have had personal conversation with, more than six out of ten of my colleagues. I do not believe this is due to any innate shyness, taciturnity or aloofness on my part. I can only conclude that there is something lacking in our contacts with one another. Obviously, one can not go about introducing himself to everyone as if he were a candidate for a political office. It seems to me that the more effective way would be to have someone introduce the strangers in the group or meeting. I feel the society is failing in this respect.

(Continued on Page 392)



Put your low-back patient back on the payroll

Soma relieves stiffness —stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

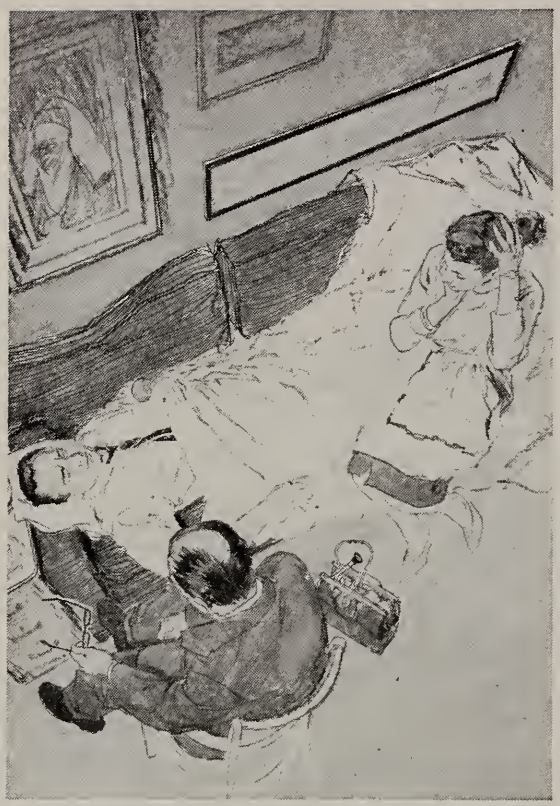
Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE:** 1 **TABLET Q.I.D.**

The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey



DORNWAL® HAS BEEN CALLED "THE GENERAL TRANQUILIZER FOR GENERAL PRACTICE."

Suppose the physician visiting this patient finds that he has to be hospitalized. Certainly he wants an alert but not excited fellow who can respond to the history and physical on admission. Depending on the condition, of course, the thing to do is to give the patient one or two tablets of Dornwal before he ever leaves his home.

Dornwal will calm the patient but won't make him drowsy or give him feelings of depersonalization. And what's more, while Dornwal most assuredly tranquilizes, it won't interfere with most other medications that your subsequent examination or laboratory studies may indicate.

Since every man in general practice encounters such situations almost daily, it makes good sense to keep some tablets in one's bag, doesn't it? We will be glad to send you a supply.

Dosage: One or two 200 mg. tablets three times a day. Children, age 6 to 16, one or two 100 mg. tablets two times a day. Administration limited to three months' duration.

Supplied: 200 mg. yellow scored tablets, and 100 mg. pink tablets, each in bottles of 100 and 500.

P.S. For the "Genericist", Dornwal is amphenidone

No absolute contraindications to the use of Dornwal are known. There have been no reports or evidence of habituation, addiction or drug tolerance in animal or clinical studies. Dornwal is relatively free from untoward effects when administered at recommended dosages.

Maltbie Laboratories Division,
Wallace & Tiernan Inc., Belleville 9, N. J.
PDW-12

Maltbie

Hail—But Heartily

(Continued from Page 390)

If every opportunity were utilized to present the various members in person by name, residence and specialty, one would have some knowledge upon which, at least, a speaking acquaintance could be founded. Undoubtedly, many of these would grow in time into friendships. If we open the door to better acquaintance, we close the way to dislike, distrust, disbelief and disharmony. We should not need a formal introduction. We belong to the same family. When we ignore, we offend; and none of us is so mighty that he can afford to squander the friendship of his fellows. If we but take the time for a friendly greeting, a few pleasantries or some stimulating conversation, we will come to know our colleague, to appreciate his abilities and to be more understanding of his faults.

There is no reason why there should be any feeling of envy, competition, strangeness or inferiority among our members in these days when there is such a shortage of trained purveyors of medical service. The economic success of a practice depends only upon the number of hours one is willing to make himself available to the people. Rivalry is stimulating to scientific achievement but it has no place in the personal relationship between men of mutual interest. It is a measure of the smallness of stature of the participant.

Let us prevent any division in our ranks along lines of specialty, staff membership or geographic location. We need each other. The society needs all of us. All together, we are the Oakland County Medical Society.

CHAUNCEY G. BURKE, M.D.,
President

Synthetic Skin

Encouraging results with a synthetic skin are reported from the Buffalo, N. Y., Veterans Administration hospital.

Aim of the research is to save the lives of persons who suffer massive burns, said William M. Chardack, M.D., who heads the project.

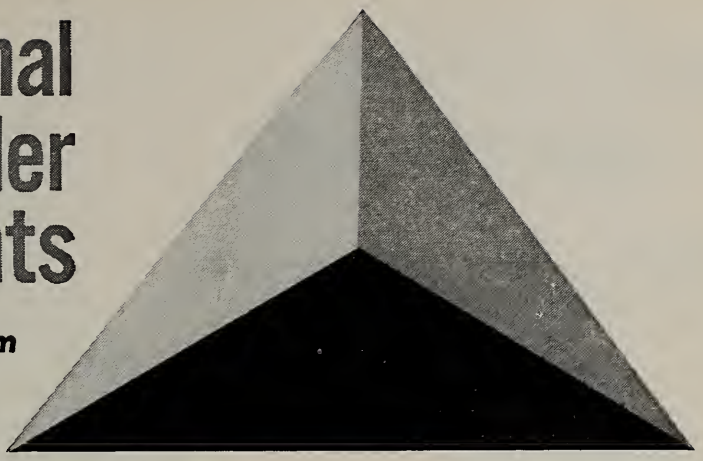
The material used is a combination of polyvinyl sponge and silicone rubber, which is rigid when dry but becomes soft, pliable and elastic when moist.

These synthetic skin grafts used in animals, have been maintained for periods up to 104 days. As the graft "takes," the surgical sponge is permeated by tissue, and firm adherence can be obtained within a few days. The skin substitute can be made waterproof by application of a coating of silicone rubber.

Dr. Chardack emphasizes that the skin prosthesis is not permanent, but they believe the material may provide a satisfactory temporary cover for tissue of burn victims that will enable these patients to improve sufficiently for staged coverage of the burned areas by successive small grafts from their own remaining uninvolved skin.

Say you saw it in the Journal of the Michigan State Medical Society

3-dimensional support for older patients



BOLSTERS... ▲ *tissue metabolism*
▲ *interest, vitality*
▲ *failing nutrition*

NEW 1 small capsule every morning

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IN MEMORIAM

THOMAS T. CALLAGHAN, M.D., sixty, Detroit surgeon, died January 13, 1961.

A native of Richwood, West Virginia, Doctor Callaghan had lived in Detroit 30 years.

He was a graduate of Johns Hopkins University and the University of West Virginia. Doctor Callaghan was former chief of surgery and chief of staff at Crittenton Hospital. During World War II he served in Africa and Italy with the 17th General Hospital.

Doctor Callaghan was a member of Phi Beta Kappa, Detroit Boat Club and medical organizations.

O. A. CAPANO, M.D., forty-eight, Detroit, chief of staff of Mt. Carmel Mercy Hospital since 1953, died January 3, 1961. A native of Rural Valley, Pennsylvania, Doctor Capano had lived in Detroit 23 years.

He was a graduate of the Loyola University Medical School in Chicago. He served his internship at Providence Hospital, Detroit, in 1937 and received his surgical training at Oakland County General Hospital. During World War II he served in the Navy, leaving the service in 1946 with the rank of Lieutenant.

FREDERICK EVANS GRANT, M.D., ninety-two, retired Kalamazoo physician died January 13, 1961.

Born in London, England, Doctor Grant was graduated from Toronto University in 1893. Later he took postgraduate work in Vienna and London and moved to Kalamazoo in 1908.

His professional affiliations included the American Academy of Ophthalmology and Otolaryngology of which he was a life member, the Michigan Triological Society and the Anglo-American Medical Association of which he was a life member.

In 1947, Doctor Grant received the Michigan State Medical Society's Fifty-Year Award.

He was active in Peninsular Commandery, Knights Templar, which organization presented him with a Fifty-Year membership certificate in 1956. He also was a member of Moslem Shrine of Detroit, Kiwanis Club, and First Presbyterian Church.

RICHARD W. McLAIN, M.D., Eighty-six, native of Williams County, Ohio, died January 6, 1961.

Doctor McLain, a physician and minister, held positions as Chaplain at the Jackson Prison and as psychiatrist at the Jackson and Ionia prisons.

JAMES EDWARD MUNRO, M.D., Eighty-one, retired Jackson physician, died January 17, 1961.

Doctor Munro was born in St. Thomas, Ontario. In 1902 he was graduated from the Saginaw Valley Medical College in Saginaw and came to Jackson where he practiced until retiring several years ago.

In 1953, he was honored with Fifty-Year Award from the Michigan State Medical Society.

Doctor Munro, for many years, was active in the old Grass Lake Rifle Club and recognized as an expert marksman.

(Continued on Page 398)

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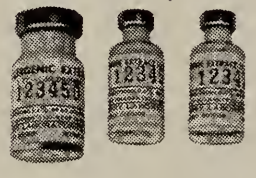
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(Continued from Page 396)

EMIL D. ROTHMAN, M.D., sixty, chief of obstetrics and gynecology at Sinai Hospital, Detroit, died January 3, 1961.

A resident of the Detroit area for 40 years, Doctor Rothman was born in New York City, and was graduated from the Detroit College of Medicine and Surgery in 1921. After internship at City Hospital, New York, he opened practice in Detroit in 1923.

He was a former president of the staff and chief of obstetrics at Highland Park General Hospital, a charter member of the College of Obstetrics and Gynecology, past grand counsellor of the Phi Delta Epsilon national medical fraternity, member of its executive board and editor of its bulletin. He was a member of the Maimonides medical organization, a founding member of the Detroit Historical Museum and a member of Temple Beth El, Detroit.

CHARLES L. WASHBURNE, M.D., Eighty-three, Ann Arbor, retired chief of staff at St. Joseph Mercy Hospital and former member of the University of Michigan Medical School faculty, died January 8, 1961.

He was a native of Ithaca, New York. A 1908 graduate of the U-M Medical School, Doctor Washburne was instrumental in helping start the orthopedics department at University Hospital and the U-M Health Service for students.

Appointed an intern at University Hospital in 1908, he progressed to the position of assistant professor of orthopedic surgery in 1918. In 1917 he was granted a leave of absence for military duty during World War I. He became head surgeon and chief of staff at St. Joseph Mercy hospital and joined the hospital's staff in 1914, retiring in 1953 after 39 years of service.

Doctor Washburne was formerly active in Masonic lodges.

COMMUNICATIONS

Wilfrid Haughey, M.D., Editor,
Journal of the Michigan State Medical Society
Battle Creek, Michigan

E. R. Squibb & Sons announced today a proposal which will provide a ten per cent allowance to those states which reimburse retail pharmacies directly for prescriptions for Squibb Products filled by pharmacies for state welfare patients.

J. SHANNON, E. R. Squibb & Sons

Telegram New York, N. Y.
February 6, 1961

Nursing Home Needs

Although there are nearly 14,000 licensed nursing homes and another 10,000 bed-and-board homes operating throughout fifty states, these provide only about 450,000 beds, one for every four aged or infirm people. In order to provide one skilled nursing home bed for every four elderly people by 1975, over 1,000,000 new beds and facilities will have to be constructed at a cost of more than 5 billion dollars.

A major step toward solution of this problem will come from the new 11 million dollar Nursing Home Research Center due for construction in Washington, D. C., in 1961.

Say you saw it in the Journal of the Michigan State Medical Society

Brief and to the Point

NEW DRUGS REPORT—The nation's smaller pharmaceutical manufacturers led the drug industry to a record breaking number of new pharmaceutical introductions during 1960, in spite of a drop in the rate of new products marketed by the major manufacturers. A total of 718 new pharmaceuticals was reported during 1960, representing an average of 3.1 products each from the 232 manufacturers announcing new items. This is slightly higher than the 1959 average of 2.7 products. The reports include the new pharmaceuticals of all national and regional American manufacturers. Pacing the increase were the 170 firms with less than full national distribution for their products. These companies increased their average rate of introduction to 3 items per firm in 1960 as compared with 2.3 products each in 1959.

* * *

MAJOR MEDICAL REPORT—Half of the group health insurance policies issued during 1960 provided a comprehensive or supplementary type of major medical expense insurance coverage. Of some 2,200 new group coverages issued last year (protecting 305,309 employees and an estimated 692,200 dependents for a total of almost one million insured individuals), 611 provided major medical benefits as a supplement to basic coverages already held by the insured, and 492 were comprehensive policies combining major medical benefits with basic coverages.

* * *

OFFER AAMA PROCEEDINGS—A compilation of speeches on medical office management and patient relations given at the annual convention of the American Association of Medical Assistants in Dallas is now available on request. The proceedings, entitled "The Challenge of the '60s," have been processed through the courtesy of Lakeside Laboratories, Inc., 1707 East North Avenue, Milwaukee 1, Wisconsin.

* * *

CANCER RESEARCH—A report by the University of Michigan Cancer Research Institute shows that U-M scientists are conducting 128 separate research projects on the problems of cancer.

The studies cover subjects ranging from fundamental physical and chemical principles to the highly complex effects of modern clinical treatment.

Many of the investigations seek new knowledge of normal growth, while other studies attempt to find variations among different kinds of cancer, the effects of hormones, and anti-cancer compounds and the clinical value of radiation.





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DR. CARR HONORED—E. I Carr, M.D., Lansing, received the Ingham County Medical Society "Doctor of the Year" award at the annual meeting in January. The award, presented by F. I. Troost, M.D., Holt, a past president of the Ingham society, cited Dr. Carr for his many contributions of time, effort and leadership to Society projects.

* * *

GRANTS AID WAYNE—The Wayne State University Board of Governors recently received grants of $244,615 for 11 projects from the U. S. Public Health Service, National Institutes of Health.

The largest of the 11 projects was $51,689 for a training program in physiology, to be conducted under the direction of Edward L. Holmes, M.D., for the 18-month period.

Other grants were $42,089 for a training program in microbiology; $32,902 for research entitled "Fluorine: Effect of Dentition When Given from Infancy," $20,039 for research entitled "Physiology of the Vagus," and $19,550 to continue research entitled "Formation and Properties of Prothrombin Derivatives."

* * *

MSMS ARCHITECT CITED—Minoru Yamasaki, Birmingham, architect of the new headquarters of the Michigan State Medical Society among many outstanding buildings, received a doctor of architecture degree at the University of Michigan mid-year graduation exercises in January.

* * *

INVITATION TO WINDSOR—The Annual Essex County Surgical Clinic, sponsored by the Essex County Medical Society, will be held in Windsor, Ontario, April 26, 27 and 28 in the new Cleary Auditorium.

The guest speakers will be Professor Ian Aird of London University, and Professor Robert M. Zollinger of Ohio State University. This meeting is cosponsored by the Surgical Division of the Ontario Medical Association.

For further information, write: The Registrar, Essex County Surgical Clinic, 301 Canada Building, Windsor, Ontario.

* * *

OFFER AGING BIBLIOGRAPHY—The National Library of Medicine has just issued a bibliography on Physiologic Involution in Normal Aging Man. Copies may be obtained at no cost upon request to the: Acquisition Section, National Library of Medicine, Washington 25, D. C.

* * *

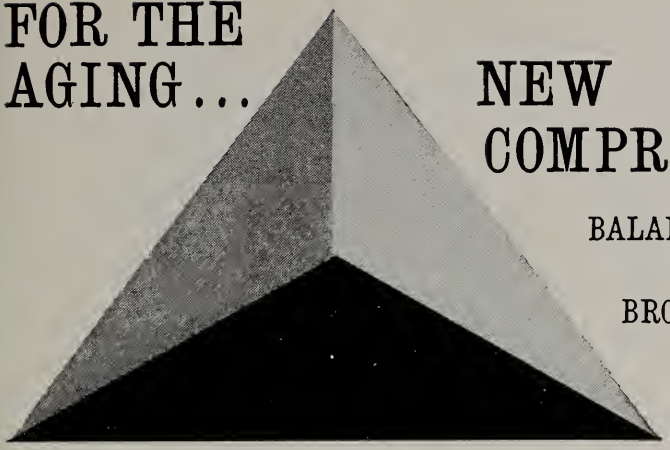
NAMED MEDICAL EXAMINERS—The medical examiner system has been launched in Barry County after its overwhelming approval by the voters in November. W. R. Birk, M.D., of Hastings, was appointed by the Barry County Board of Supervisors as the first county medical examiner. Three other doctors of medicine were named deputy medical examiners—Douglas Castleman, M.D., Robert Huebner, M.D., and Ray Finnie, M.D., all of Hastings.

* * *

MICHIGAN INDUSTRIAL MEDICAL ASSOCIATION—The Annual Meeting of the Michigan Industrial Medical Association is to be held March 24, 1961 at the Statler Hilton Hotel in Detroit. They extend an invitation to

(Continued on Page 402)

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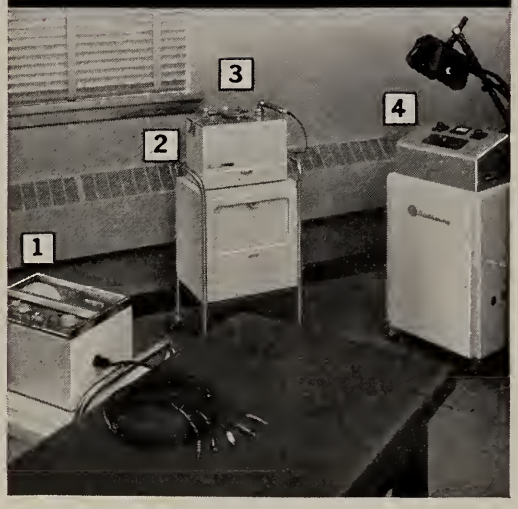
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(Continued from Page 400)

any interested members of the medical profession who might wish to attend. We have been informed by the Michigan Academy of General Practice that five hours Category II Credit will be granted for attendance at this meeting.

* * *

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY ANNOUNCES—the next scheduled examinations (Part II), oral and clinical for all candidates at the Edgewater Beach Hotel, Chicago, April 8 through 15. The deadline date for the receipt of new and reopened applications for the 1962 examinations is August 1.

* * *

EIGHTY-FIVE PRACTICING PHYSICIANS completed recent postgraduate courses in pediatrics, obstetrics and gynecology at The University of Michigan Medical Center. The week-long program, featuring U-M faculty members and guest lecturers, was geared to common problems arising in maternal and child care.

* * *

50TH ANNIVERSARY—As the Army Dental Service reaches its first half century mark in March, the watchword of the future is "Prevention." Major General Joseph L. Bernier, new chief of the Dental Corps, has launched a Corps-wide campaign to maintain the dental health of the Army at an all-time high.

"The loss of manhours due to dental causes constitutes a significant military problem," General Bernier says. "Men away from duty, even for a short time, may seriously interfere with operations and training in our present mechanized and specialized Army."

* * *

DOCTOR FALLS HONORED—A greatly expanded program of information to the public on the meaning and value of good eye care is planned for 1961 by the National Medical Foundation for Eye Care. The Foundation was organized in 1956 as a public educational agency for American ophthalmology, and most of its 3,000 members are Diplomates of the American Board of Ophthalmology.

The Foundation's Board of Trustees, at its recent Annual Meeting, re-elected Ralph O. Rychener, M.D., of Memphis as president for a fifth term. Harold F. Falls, M.D., of Ann Arbor, was elected chairman of the Executive Committee.

The Foundation's public information program has several main features: (1) a series of monographs on major socio-economic and organizational problems confronting ophthalmology. These are widely distributed to editors, publicists and other "opinion makers"; (2) a series of popular pamphlets on eye care topics, of which nearly 3,000,000 copies have been distributed during the past four years largely through physicians' offices; (3) an informational and advisory service for popular magazine editors and science writers; and (4) periodic stories and educational material for medical journals, newspapers and radio-TV outlets.

* * *

SPEAKER—Ralph S. Green, M.D., Rochester, delivered a paper on "The Adjunctive Therapies with Specific Considerations of Regressive Potentials," before the National

(Continued on Page 404)



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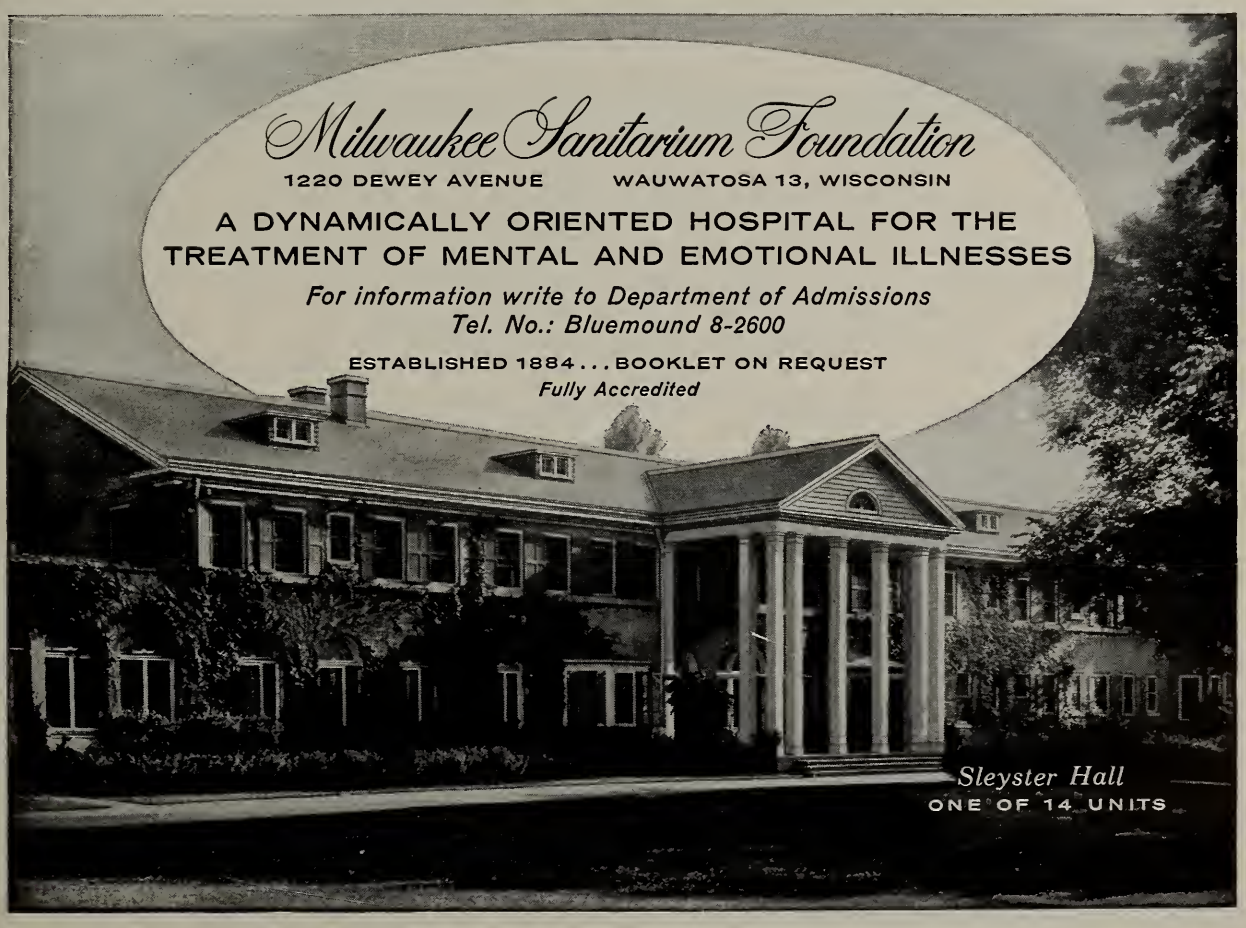
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(Continued from Page 402)

Association of Private Psychiatric Hospitals at the Phoenix annual meeting in January.

* * *

ANNOUNCE CAMP—The Summer Camp for Diabetic Children will be conducted for the thirteenth year by the Chicago Diabetes Association, July 16 through August 6, at Holiday Home, Lake Geneva, Wisconsin. Boys and girls from eight through fourteen years of age are eligible. Applications may be obtained from Chicago Diabetes Association, 620 North Michigan Avenue, Chicago 11, Illinois.

* * *

RECEIVES TRIBUTE—Robert Murray, M.D., Trenton, was cited recently for his efforts on behalf of the Red Cross blood program in the Downriver area.

In making the presentation, Mrs. Frederick C. Weyher, chairman of the chapter's field service, paid tribute to the service Dr. Murray gave in securing volunteer physicians to staff monthly visits of the Red Cross bloodmobile to the Downriver regional office. She said that since he and the Southeastern Medical Association accepted the assignment, Dr. Murray has been "on duty" four out of 17 times.

* * *

MEDICAL TELEVISION SHOWS—The Michigan Health Council reports that the following topics were covered during the month of January, 1961 on the weekly Sunday morning program over WJBK-TV, Detroit: Home Safety, School Health, Nutrition, and Heart Disease.

* * *

COOPERATIVE AGREEMENT—After operating under a verbal agreement for many years, Wayne County General Hospital and Wayne State University College of Medicine have signed a written affiliation agreement. Use of Wayne County General for clinical teaching purposes will continue to be shared with the University of Michigan Medical School. A joint administrative committee will be composed of representatives from Wayne County Board of County Institutions, Wayne County General Hospital and the two medical schools.

MEDICAL MEETINGS U.S.A.

Spring Meeting of American Academy of Pediatrics, April 10-12, 1961, Sheraton-Park Hotel, Washington, D. C. For information write E. H. Christopherson, M.D., 1801 Hinman Ave., Evanston, Ill., Executive Director.

Clinical Reviews, Mayo Clinic and Mayo Foundation, April 10-12, 1961, Rochester, Minnesota; for information contact Clinical Reviews Committee, Mayo Clinic, Rochester, Minnesota.

Ohio State Medical Association, April 10-13, 1961, Netherland-Hilton Hotel, Cincinnati, Ohio. Charles S. Nelson, 79 E. State St., Columbus 15, Executive Secretary.

Industrial Medical Association, April 11-13, 1961, Biltmore Hotel, Los Angeles, Calif. Clark D. Bridges, Managing Director, 28 E. Jackson Blvd., Chicago, Ill.

American Academy of General Practice, April 13-20, 1961, Miami Beach, Fla. Mac F. Cahal, Volker Blvd. at Brookside, Kansas City 12, Mo., Executive Director.

(Continued on Page 406)



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(Continued from Page 404)

Fifth Post-Graduate Course on Fractures and Other Trauma sponsored by the Chicago Committee on Trauma of the American College of Surgeons, April 19-22, 1961, John B. Murphy Memorial Auditorium, 50 East Erie Street, Chicago.

American College of Obstetricians and Gynecologists, April 21-28, 1961, Americana Hotel, Miami Beach, Fla. Donald F. Richardson, 79 W. Monroe St., Chicago 3, Ill., Executive Secretary.

Thirty-Second Annual Meeting of Aerospace Medical Association, April 24-26, 1961, Chicago. Willion J. Kennard, M.D., c/o Washington National Airport, Washington, D. C., Secretary-Treasurer.

American Association for Thoracic Surgery, April 24-26, 1961, Sheraton Hotel, Philadelphia, Pa. Hiram T. Langston, M.D., 308 Carondelet Bldg., 7730 Carondelet Ave., St. Louis 5, Secretary.

American Pediatric Society, May 2-3, 1961, Hotel Traymore, Atlantic City. Conrad M. Riley, Denver General Hospital, Denver 4, Secretary.

Student American Medical Association, Congress, May 3-7, 1961, Chicago. Russell F. Staudacher, 430 N. Michigan Ave., Chicago 11, Executive Director.

American Society of Internal Medicine, May 5-7, 1961, Eden Roc Hotel, Miami Beach, Fla. G. Tod Bates, 350 Post St., San Francisco 8, Executive Director.

American College of Physicians, May 8-12, 1961, Americana Hotel, Miami Beach, Fla. Edward C. Rosenow, Jr., M.D., 4200 Pine St., Philadelphia 4, Executive Director.

American Psychiatric Association, May 8-12, 1961, Morrison Hotel, Chicago. C. H. Hardin Branch, M.D., 156 Westminster Ave., Salt Lake City 15, Utah, Secretary.

International College of Surgeons, North American Federation Congress, May 15-18, 1961, Palmer House, Chicago. Horace E. Turner, M.D., 1516 Lake Shore Drive, Chicago, Secretary General.

Illinois State Medical Society, May 15-18, 1961. R. Richards, 360 N. Michigan, Chicago 1, Executive Administrator.

American College of Cardiology, Inc., May 16-20, 1961, Biltmore Hotel, Philip Reichert, M.D., 350 Fifth Ave., Empire State Bldg., New York 1, Executive Director.

American Association of Plastic Surgeons (members and guests), May 17-19, 1961, Commodore Hotel, New York City. Thomas D. Cronin, M.D., 6615 Travis St., Houston 25, Texas, Executive Secretary.

American Orthopaedic Association (members and guests), May 22-25, 1961, The Ahwahnee, Yosemite, Calif. Lee Ramsay Straub, M.D., 535 E. 70th St., New York 21, Secretary.

American Urological Association, Inc., May 22-25, 1961, Biltmore Hotel, Los Angeles. William P. Didusch, 1120 N. Charles St., Baltmore 1, Executive Secretary.

National Tuberculosis Association, May 22-25, 1961, Netherland-Hilton, Cincinnati. James G. Stone, 1790 Broadway, New York 19, Executive Secretary.

American Otological Society, Inc., May 26-27, 1961, Lake Placid Club, Essex County, N. Y. James A. Moore, M.D., 525 E. 68th St., New York 21, Secretary-Treasurer.

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American Gynecological Society, May 29-31, 1961, The Broadmoor, Colorado Springs, Colo. Albert H. Aldridge, M.D., 899 Park Ave., New York 21, President.

American Neurological Association, June 12-14, 1961, Hotel Claridge, Atlantic City. Melvin D. Yahr, M.D., Neurological Institute, 710 W. 168th St., New York 32, Executive Secretary.

American Dermatological Association, Inc. (members only), June 16-20, 1961, Castle Harbour Hotel, Tucker's Town, Bermuda. Wiley M. Sams, M.D., 25 S.E. Second Ave., Miami 32, Fla., Secretary.

American Proctologic Society (members and guests), June 21-24, 1961, Pittsburgh Hilton Hotel, Pittsburgh. Norman D. Nigro, M.D., 10 Peterboro St., Detroit, Secretary.

American Rheumatism Association, June 22-23, 1961, Hotel Roosevelt, New York City. Gerald W. Speyer, 10 Columbus Circle, New York 19, Executive Secretary.

American Geriatrics Society, June 22-23, 1961, New York City. Richard J. Kraemer, M.D., 2907 Post Rd., Greenwood, Warwick, R. I.

American College of Chest Physicians, June 22-26, 1961, Hotel Commodore, New York City. Murray Kornfeld, 112 E. Chestnut St., Chicago, Executive Director.

American Diabetes Association, Inc., June 24-25, 1961, Commodore Hotel, New York City. J. Richard Connelly, M.D., 1 E. 45th St., New York 17, Executive Secretary.

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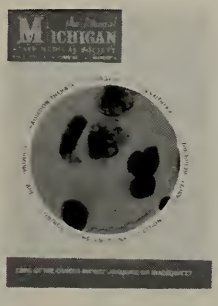
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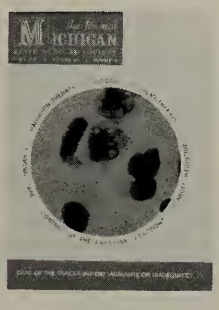
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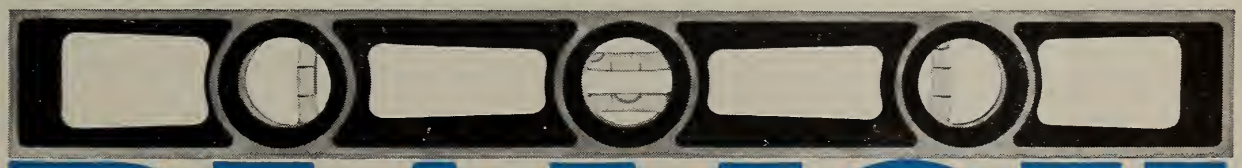
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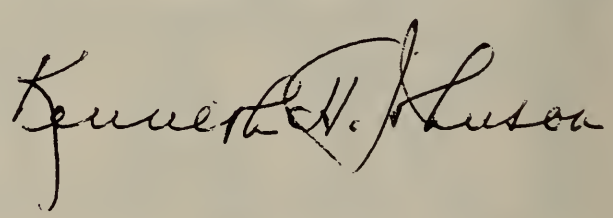
As Doctors of Medicine, we have no special rights, but have been granted many privileges after taking a prescribed training in the science of medicine and have passed certain examinations to make sure that we are qualified. With these privileges, naturally, come obligations and duties that go far beyond the requirements of law. If there were only financial rewards, many of us would not be in or stay in the practice of medicine, I am sure.

The greatest joy that comes to doctors is being a part of the lives of people; oneness with them in pain and sickness, and a feeling of elation when they make satisfactory progress toward health.

Medicine has been good to me. If this were not so, I could not give my whole heart to everything that elevates the practice of medicine. Our new MSMS headquarters building in Lansing will always be a symbol of the dignity of Michigan Doctors of Medicine who are trying to promote better health and care for all people in our State.

With adequate working space and a highly trained, willing staff, we are now in a better position to promote postgraduate medical training, to give better health information to our citizens, to assist our medical schools in training better doctors, and at the same time to interest more and better trained younger men in medical science.

Our new home in Lansing is attractive without being ostentatious. Without doubt, it lends dignity to the medical profession. My duty as an MSMS member calls on me to give a small annual fee to complete this building, but in addition it is my pleasure to contribute substantially to furnish this home because "Medicine has been good to me," to quote W. S. Jones, M.D., of Menominee, Chairman of our new building committee. I believe there are a good many doctors in our State who also feel that Medicine has been good to them, and now we all have an opportunity to show our thanks by giving a special contribution to help furnish this home which will always be a credit to the Doctors of Michigan.



New Headquarters Gifts Received



Five additional gifts to the MSMS Headquarters Building have been announced.

W. S. Jones, M.D., and Mrs. Jones of Menominee, chairman of the MSMS new building committee and a past president of the Society, has contributed $1,000.

The Shook family has presented $1,000 in memory of the late Ralph W. Shook, M.D., Kalamazoo, long-time chairman of the Finance Committee of the MSMS Council before his death in 1959.

Mrs. L. Fernald Foster, Detroit, contributed a $1,000 memorial honoring long-time MSMS Secretary, L. Fernald Foster, M.D., who passed away May 27, 1959.

The fourth recent gift of $1,000 was received from the Bruce Publishing Company, St. Paul and Minneapolis, publishers of the MSMS JOURNAL.

A gift of $500 has been accepted from Wellman Press, Inc., of Lansing.

These gifts and others already announced were gratefully received by The MSMS Council on behalf of the total membership. Other gifts and memorials are welcome and will be used for special equipment required in the new headquarters building.

Come to Dedication, Dr. Askey to Speak

The detailed program for the dedication of the new MSMS Headquarters Building is being completed now for Sunday, June 4.

All members of MSMS and their ladies are urged to attend the event. Special invitations are being extended to the members of the MSMS House of Delegates and to The MSMS Council.

An impressive dedication program will begin at 3 p.m. The preliminary plans were approved by The Council and are now being implemented by the Big Look Committee, The Council and the MSMS officers.

The major speaker at the dedication will be E. Vincent Askey, M.D., of California, president of the American Medical Association. He has accepted an invitation from MSMS President Kenneth H. Johnson, M.D., to participate in the ceremony.

Preceding the dedication program will be a flag-raising ceremony at 2:30 p.m.

The Sunday, June 4, program will be the major event; however, a series of open-house programs will follow for leaders in government, the health field, community affairs and other areas of activity.



Three Detroiters—presidents of national groups—admire their President's Awards: Martin H. Hoffman, M.D., Central Neuropsychiatric Association; Mrs. William G. Mackersie, Woman's Auxiliary to the American Medical Association, and C. Paul Hodgkinson, M.D., American College of Obstetricians and Gynecologists. All ten awards were made at the annual County Secretaries-Public Relations Seminar.

Ten MSMS Awards Recognize Outstanding Service



Receiving his award from President Johnson is Charles H. Frantz, M.D., Grand Rapids, president, Clinical Orthopedic Society.



Robert A. Hoving, accepted the "Outstanding Health Service Award" given to the *Jackson Citizen-Patriot*.



Jack Pickering, science editor for the former *Detroit Times*, receives his "Outstanding Health Service Award."



Dirk Gringhuis, East Lansing, was presented an "Outstanding Health Service Award" for his work as former art director for MSMS publications.

Reid, Sligh and Niehuss Honored



Robert L. Novy, M.D., right, Detroit, on behalf of the Michigan Medical Service and Michigan State Medical Society, presented a distinguished service award to John Reid, Lansing, for his many years as a director of Michigan Medical Service.



Charles R. Sligh, Jr., Holland, chairman of the board of the Deafness Research Foundation, received an "Outstanding Health Service Award."



Two Ann Arbor recipients of "Outstanding Health Service Awards" visit with Dr. Johnson. At left, Marvin L. Niehuss, former president of the Michigan Health Council, and center, Ed Burrows, who accepted for Radio Station WUOM.

MICHIGAN MEDICAL MEETINGS AND CLINIC DAYS

April 26-29	American College Health Association	Detroit
April 27-29	American Academy of Neurology	Sheraton-Cadillac Hotel, Detroit
May 3	Wayne State University Clinic Day and Alumni Reunion	Hotel Shelby, Detroit
May 23-25	Michigan Health Council State Conference	Ballengar Field House, Flint Community College, Flint
June 4	Dedication of New MSMS Headquarters	East Lansing
June 16-17	Upper Peninsula Medical Society	Menominee
June 19-21	University of Michigan Conference on Aging	Rackham Bldg.,Ann Arbor
July 27-28	Coller-Penberthy Clinic	Park Place Hotel, Traverse City



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REFERENCES: 1.) Council on Dental Therapeutics: Prescribing Supplements of Dietary Fluorides, J. Am. Dental Assoc. 56:589 (April) 1958. 2.) Treiger, N.: Fluoride Administration: Role of the Pediatrician, Delivered at New England Pediatrics Society Meeting, Boston, March 16, 1960. 3.) Arnold, F. A. Jr., McClure, F. J. and White, C. L.: Sodium Fluoride Tablets for Children, Dental Progress 1:3-12 (October) 1960. 4.) Hall, E. W.: The Family Doctor and Preventive Dentistry, GP 22:109-111 (December) 1960. 5.) Council on Foods and Nutrition: Vitamin Preparations as Dietary Supplements and as Therapeutic Agents, J.A.M.A. 169:110 (Jan. 3) 1959. 6.) May, C. D.: Editorial, Pediatrics 23:833 (May) 1959. 7.) Sebrell, Jr., W. H.: Vitamins in Medical Practice, Seminar Report 3:2 (Fall) 1958. 8.) Smith, D. W., Blizzard, R. M. and Harrison, H. E.: Idiopathic Hypercalcemia, Pediatrics 24:268 (August) 1959. 9.) György, P.: Infant Nutrition, Modern Medicine 28:76 (August 1) 1960. 10.) Sebrell, Jr., W. H.: Vitamins in Modern Medicine, Modern Medicine 28:79-80 (August 1) 1960. 11.) Eagle, J. F.: Feeding the Infant, N. Y. State Jrl. of Med. 60:1822 (June 1) 1960.

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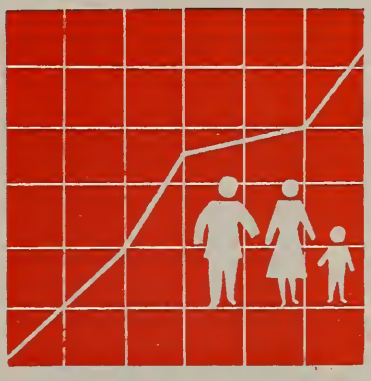
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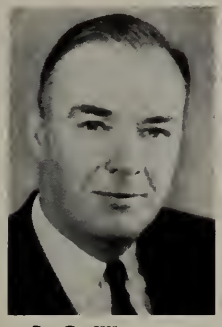
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Blue Shield Names Executive Director

Sumner G. Whittier, former chief of the Veterans Administration and former lieutenant governor of Massachusetts, is the new executive director of Michigan Medical Service.



S. G. Whittier

The Blue Shield board, in announcing the appointment recently, also adopted a resolution commending L. Gordon Goodrich, who had been acting executive vice president for his "notable contributions to the Blue Shield movement." Mr. Goodrich will continue as Vice President in charge of Administration and Operations under Whittier.

Mr. Whittier, a native of Everett, Massachusetts, is forty-nine years old and a graduate of Boston University. In addition to holding five honorary degrees from Eastern colleges and universities, he has a long record of public service. He is a former member of the Massachusetts State House and Senate.

Before being appointed by President Eisenhower to the top Veterans Administration post, Mr. Whittier was chief insurance director of that organization. As such, he ran the largest ordinary life insurance program in the United States. He became Administrator of Veterans Affairs in December, 1957. In this position, he was responsible for the agency which serves more than 22 million war veterans and their families. This also put him in charge of the largest medical program in the United States, consisting of 170 hospitals and outpatient clinics.

He also served as a member of the President's Committee on the Employment of the Physically Handicapped, and as a member of the Federal Council on Aging and the National Housing Council. For these contributions, Whittier received a Distinguished Service Award from President Eisenhower for encouraging and promoting the employment of the physically handicapped.

At the time of his appointment, Mr. Whittier emphasized his belief in the free enterprise systems of all professional activities. He stated categorically his opposition to any plan tending to the socialization or the control of medical practice by the government.

Previously, Mr. Whittier has published vigorous criticism of any medical care tied to Social Security mechanisms for payment.

AMA Sponsors Medicolegal Conference in New York

The Medicolegal Conference will be presented at the Statler-Hilton Hotel in New York, April 28-29, sponsored by the American Medical Association's Legal and Socio-Economic Division. Speakers will include Crawford Morris of Cleveland, an authority on Res Ipsa Loquitur; Lou Ashe of San Francisco, immediate past president of the National Association of Claimants' Compensation Attorneys; and Judge Irving Goldstein of Skokie, Illinois, co-editor of *The Medical Trial Quarterly*.

The New York meeting, the final one in a series of three medicolegal meetings being sponsored by the AMA this year, will have

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registrants from New York, Michigan, Pennsylvania, Maryland, Washington, D. C., Delaware, New Jersey, Maine, New Hampshire, Vermont, Massachusetts, Connecticut and Rhode Island.

Advance registration cards may be obtained by writing: C. Joseph Stetler, Director, Legal and Socio-Economic Division, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

Blue Shield Film for Schools Stresses Individual Responsibility

Almost 3,000 prints of the new Blue Shield sound and color filmstrip, "The Guardians," have been distributed to secondary schools.

The Blue Shield filmstrip, produced as a public service, seeks to give young people an understanding of the never-ending struggle by the medical profession to overcome disease, and of the progress of medicine through the ages, with emphasis on the dramatic advances made within the Twentieth Century. Specifically, this national Blue Shield filmstrip seeks to develop appreciation of the contribution to the public's health made by the "guardian" of health, the Doctor of Medicine, and to encourage students to become more aware of the need for development of individual responsibility.

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Treatment of Carcinoma of the Thyroid Gland

Oliver H. Beahrs, M.D.
Lewis B. Woolner, M.D.
Rochester, Minnesota



THE TREATMENT of carcinoma of the thyroid gland remains a controversial subject today, since articles in the medical literature and speakers in the medical meeting halls and classrooms advocate wide variations in the therapeutic methods. Some physicians hold that certain malignant lesions should not be treated surgically at all;[1] and some advise only conservative surgical measures[4,5] while others recommend radical surgery for the same lesions.[9,12-14,16,17] It is generally recognized that the types of cancer occurring in the thyroid gland vary considerably in their degrees of malignancy. As this fact is acknowledged and authors carefully define and separate the types of carcinoma and statistics that are reported, more valid bases for decisions on therapy will become available.

In general, carcinomas of this gland can be divided into two groups: (1) those of low degree of malignancy, the majority of which are papillary carcinomas; and (2) those of high degree of malignancy, the anaplastic carcinomas. The two groups differ decidedly in pattern of behavior. For the anaplastic lesions of the thyroid gland, present methods of treatment are inadequate and the survival rate is extremely low; for the other group the present methods of treatment are mostly—though not uniformly—adequate, and the prognosis is excellent. Because of these wide variations in prognosis, the types of carcinoma must not be confused and must be discussed separately. The individual basis of biologic variability in cancer has been discussed by Macdonald,[11] who concluded that "each patient is an individual problem; the attack on a specific neoplasm should be conditional upon a knowledge of its usual biologic pattern and the best evaluation possible of its behavior in the individual."

General Clinical Considerations

Before a detailed discussion of the management of carcinoma of the thyroid gland, we should offer a general answer to the question, Which goiter should be removed?

In 1951, with Pemberton and Black, we reviewed our position on nodular goiter and malignant lesions of the thyroid gland. This was done primarily because more than 30 per cent of the carcinomas of the thyroid gland seen at the Mayo Clinic between

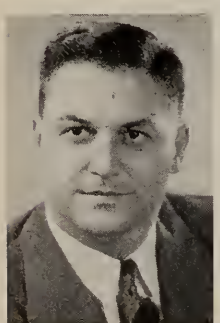
Read at the meeting of the Detroit Academy of Surgery, March 10, 1960.

Dr. Beahrs is from the Section of Surgery and Dr. Woolner, from the Section of Surgical Pathology, Mayo Clinic and Mayo Foundation, Rochester, Minnesota. The Mayo Foundation is a part of the Graduate School of the University of Minnesota.

1938 and 1947, inclusive, were considered inoperable. The high incidence of inoperability was considered the more unfortunate because the majority of these patients could have been cured had they been seen earlier in the course of the disease.

The number of cases in this period was 360, and the number inoperable was 121. The yearly incidence of carcinoma in surgically treated nodular goiters was 4.8 per cent. Unsuspected carcinoma was discovered in 3.8 per cent of the asymptomatic adenomatous goiters operated on. This figure is much lower than that in many reported series and undoubtedly is explained by the fact that for many years patients with nodular goiter have been advised to have the goiter removed prophylactically, irrespective of the clinical diagnosis.

In a series of 1,000 consecutive necropsies Mortensen and associates found an incidence of nodular goiter of 52.5 per cent. The incidence of unsuspected primary carcinoma in nodular goiter was 5.3 per cent, or 2.8 per cent in the total series. The occurrence of unsuspected carcinoma in surgical and necropsy material might be considered too low to warrant recommending thyroidectomy in asymptomatic goiter, especially in light of the fact that the majority of these lesions are of a low degree of malignancy. The over-all risk of thyroid surgery at the Mayo Clinic is less than 1 per cent, however, and in surgery for asymptomatic goiter it is 0.05 per cent. In addition to the hazard of carcinoma in asymptomatic nodular goiter, hazards of subsequent development of hyperthyroidism and of pressure on structures of the neck, especially those about the airway, must be considered. Too often a patient seventy years of age comes into the office with cardiac fibrillation and cardiac decompensation as results of a nodular goiter with hyperthyroidism. The patient's serious condition could have been prevented had an adenomatous goiter known to have been present for twenty to thirty years been removed earlier. Hyperthyroidism has been variously estimated to develop in 10 to 20 per cent of the cases of untreated adenomatous goiter. Also, a cervical goiter may displace structures of the neck or impinge on the thoracic inlet, causing embarrassment of the airway or obstruction to blood flow. Thyroidectomy is required in these situations, but the surgery could have been carried out more safely at a time prior to development of symptoms.



Authors

OLIVER H. BEAHRS, M.D. *(left)*

LEWIS B. WOOLNER M.D. *(right)*



These statements may suggest that all nodular goiters seen at the Mayo Clinic are consigned to the scalpel, but they are not. Thyroidectomy is performed on only 25 to 30 per cent of patients with a clinical nodular goiter. This figure is rather low, because considerable selection is exercised in recommending thyroidectomy. For the patient sixty-five years old having a small, soft, multiple adenomatous goiter that has been present for many years, a recommendation of thyroidectomy is rare. On the other hand, if the goiter is generous in size with discrete nodules, one or more of which are firm, and the history indicates that the goiter is enlarging, the patient is urged to have a thyroidectomy. Size and duration are not always factors in the decision as to whether thyroidectomy is indicated; often the consistency of the goiter is influential. Younger patients are more likely to be advised to have the goiter removed, as are those with discrete or single nodules. Any patient in the pediatric age group (15 years or less) with a nodular goiter would be urged to have a thyroidectomy. In this group the chance of carcinoma being present is over 50 per cent. Actually, the incidence of carcinoma in nodular goiter in children at the Mayo Clinic is 70 per cent,[8] but this percentage is abnormally high because of the large number of patients with established carcinoma of the thyroid gland who are referred to the clinic for management; fifty-nine now being studied.

Histologic Classification

The histologic classification of malignant lesions of the thyroid is not fully standardized as yet, and there may be some disagreement among pathologists as to the best method of classifying the more slowly growing types of carcinoma. At the present time, however, a satisfactory and practical classification is evolving in a Mayo Clinic study of 885 cases of thyroid carcinoma diagnosed and treated over a thirty-year period (1926 through 1955). The simplified classification used in this study divides the tumors into four main types: (1) those of low degree of malignancy, namely papillary; (2) the follicular; (3) the solid; and (4) those of high degree of malignancy, the anaplastic.

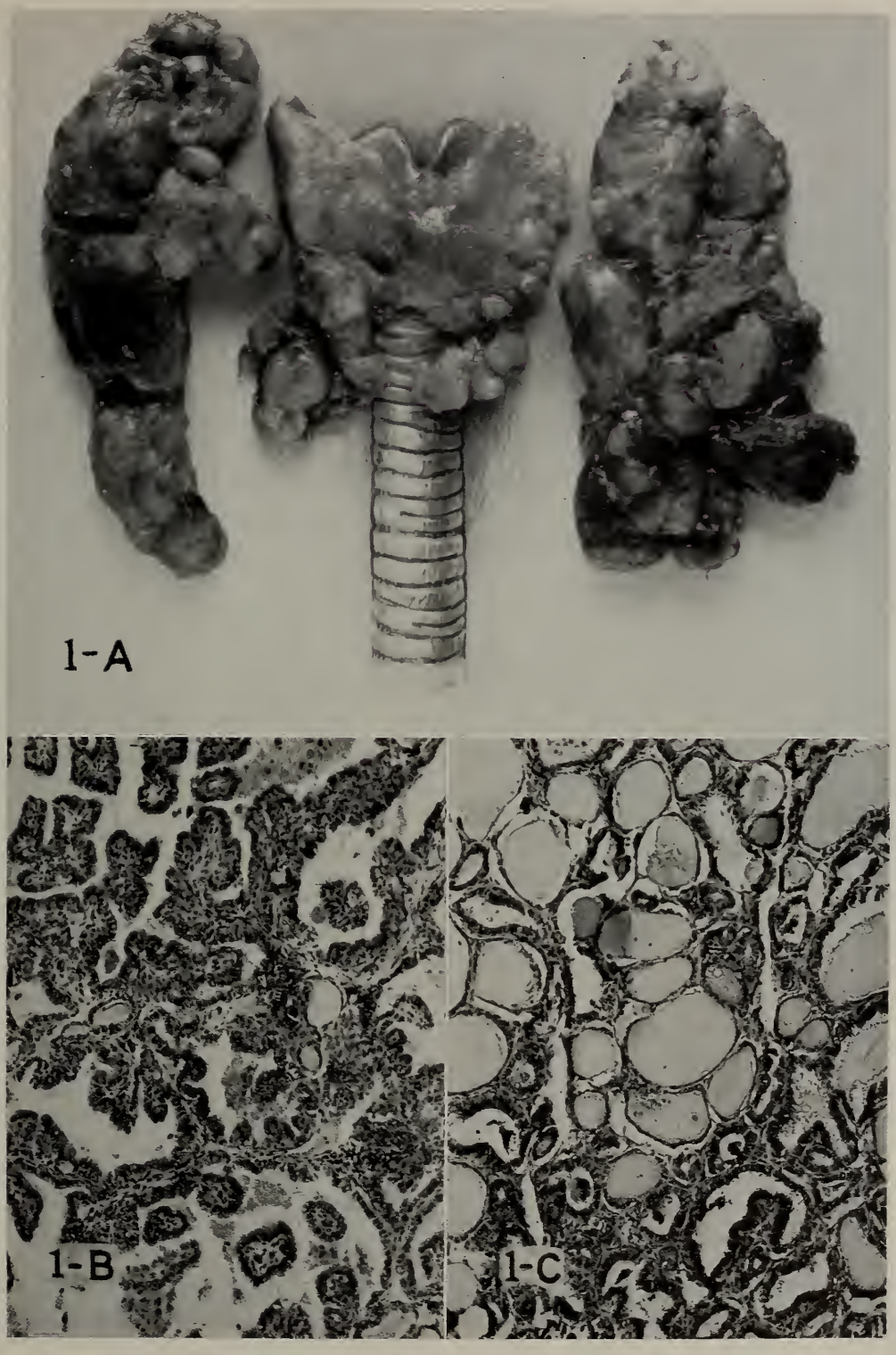


Fig. 1. Papillary adenocarcinoma. *(a)* Extensive lesion involving the entire thyroid gland with massive metastatic involvement of the tracheo-esophageal and cervical nodes. *(b)* Section of a tumor predominantly papillary in architecture (hematoxylin and eosin; magnification reduced from ×120). *(c)* Section of another lesion of mixed papillary and follicular formation (hematoxylin and eosin; magnification reduced from ×120).

Papillary Carcinoma.—Of all the lesions, 61 per cent were papillary carcinomas. These are well-differentiated tumors that usually show a striking mixture of papillary and follicular structural components (Fig. 1). A few are almost completely papillary in architecture, while at the other extreme some may be almost entirely follicular, with the papillary component minimal. Occasionally the me-

tastatic involvement of a node may be predominantly papillary while the primary lesion is predominantly follicular in architecture. These tumors invade parenchymal or extrathyroidal structures and metastasize primarily to regional lymph nodes and occasionally to distant sites. The following subdivision of papillary carcinoma into three groups according to the size and extent of the primary lesion at the initial operation was useful.

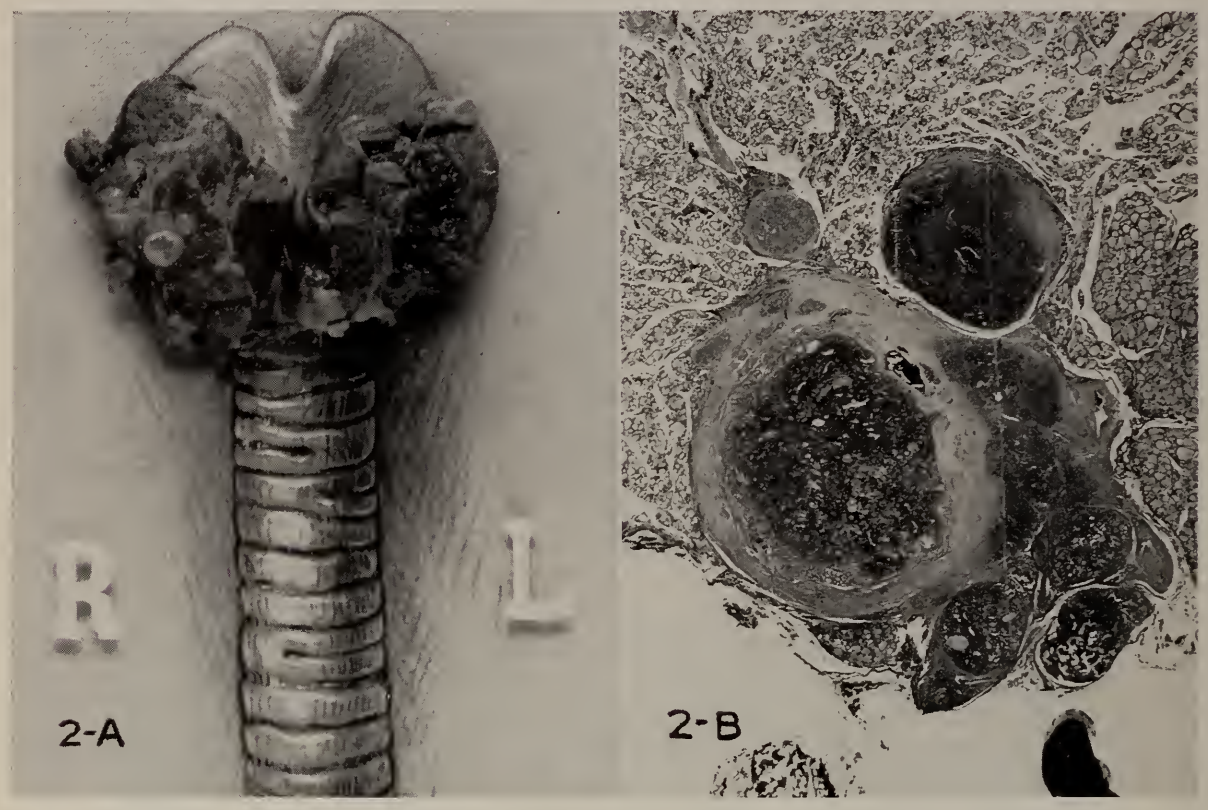


Fig. 2. Follicular carcinoma. *(a)* Primary lesion less than 1 cm. in diameter, grossly appearing encapsulated, in right lobe. *(b)* Lesion is largely encapsulated but with extension into thyroid tissue and vascular spaces. Patient had metastasis to rib and vertebral column. (Hematoxylin and eosin; magnification reduced from ×10).

Group 1.—Approximately 28 per cent of papillary carcinomas were classified as "occult" in that the primary tumor was less than 1.5 cm. in diameter (average 7 mm.) and frequently not palpable on clinical examination; 42 per cent of these occult carcinomas had metastasized to nodes when the patients were admitted. These small papillary tumors may be detected by enlargement of the cervical nodes or may be found in the course of surgical procedures for other conditions in the thyroid gland. Almost complete follow-up data indicate an excellent prognosis for this group, there being no deaths from carcinoma during as long as thirty-four years of observation.

Group 2.—Approximately 53 per cent of papillary carcinomas were larger than the occult size but grossly were confined within the thyroidal capsule. Metastasis to the lymph nodes was noted in 32 per cent of the cases. Excellent results following treatment were recorded in this group also, with only a few deaths from recurrent carcinoma in the midline of the neck or from pulmonary metastasis.

Group 3.—In approximately 18 per cent of cases of papillary carcinoma, either the lesion was considered inoperable when first seen or a palliative resection was performed. In the latter cases, invasion of adjacent structures was noted by the surgeon and the attainment of complete eradication was doubtful. Follow-up data in inoperable cases showed that approximately 60 per cent of the patients died during the period of observation. Approximately a fourth of the patients having palliative resection died, whereas the remainder were living and well.

Follicular Carcinoma.—Of the entire series, 18 per cent were follicular carcinomas, which are non-papillary neoplasms usually encapsulated (Fig. 2).

Nodal spread from these is extremely infrequent and most deaths are due to blood-borne metastasis to lungs or bone. Many of these tumors are of the functioning type, especially so in the absence of

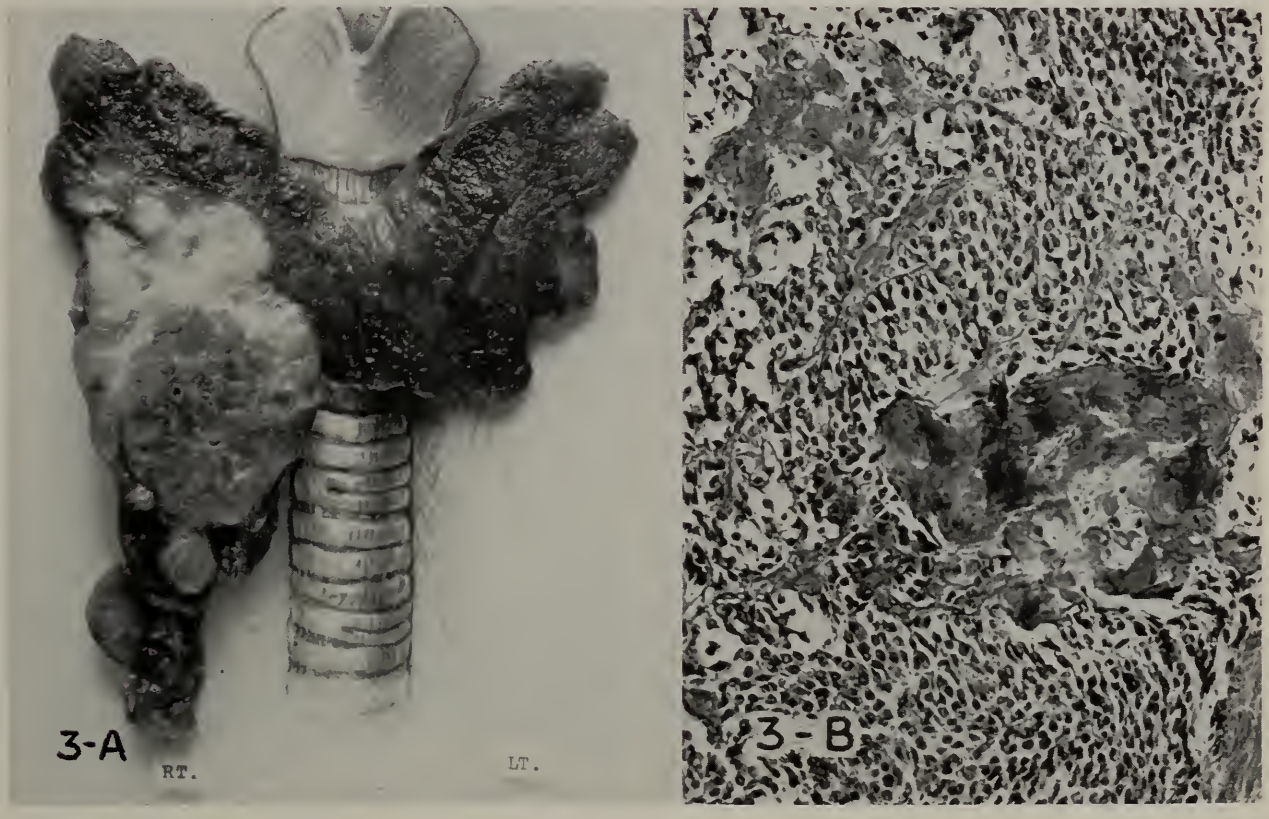


Fig. 3. Solid carcinoma with amyloid stroma. *(a)* Circumscribed unencapsulated tumor involving right lobe of thyroid gland with metastasis to tracheo-esophageal nodes. *(b)* Section showing solid sheet of cells and area of amyloid-like stroma (hematoxylin and eosin; magnification reduced from ×200).

normal thyroid tissue. Of all carcinomas of the thyroid gland this is the one which on occasions can best be treated with radioactive iodine. Although survival statistics are not quite so good as those for the papillary lesions, they still are very favorable. A number of long-term survivals associated with bony metastasis were noted in this group.

Solid Carcinoma.—Accounting for 6 per cent of all malignant growths in the thyroid gland, solid carcinomas are circumscribed but unencapsulated lesions of slow growth. Abundant amyloid stroma is a rather constant finding in these tumors (Fig. 3). The pattern of metastasis is similar to that of papillary carcinoma (more than 50 per cent to regional nodes), but the clinical behavior is more aggressive, with death resulting from tumor in approximately 33 per cent of cases.

Highly Malignant Neoplasms.—About 15 per cent of the series were highly malignant neoplasms, composed primarily of the anaplastic carcinomas (Fig. 4). These lesions grow rapidly and many were inoperable when first seen. The prognosis is very poor, with approximately 11 per cent of patients living longer than three years.

For completeness it should be mentioned that the series of 885 cases included also rare histologic types, such as osteogenic sarcoma and squamous cell carcinoma, as well as primary lymphosarcoma of the thyroid gland.

Review of Papillary Carcinoma

Experience.—In order to evaluate our treatment of the largest group of carcinomas of the thyroid gland, we have reviewed recently all cases of papillary carcinoma seen between 1938 and 1947, inclusive.[3] This period was taken so that a ten-year follow-up period would be available for all cases and a fifteen-year follow-up for many. One hundred-fifty patients were treated, definitive surgery being done in 136 cases. Fourteen patients had palliative treatment. Thirteen of these had only biopsy, for their

lesions were inoperable. The other had palliative lobectomy; at the time of operation gross carcinoma remained in the midline portion of the neck. The treatment and survival rates for the 136 patients

In sixty-four cases there was metastasis to cervical lymph nodes. Except in a few, the presence of these lesions was known or suspected before operation. Fifteen (11 per cent) of the 136 thyroid glands



Fig. 4. Anaplastic carcinoma. *(a)* Gross specimen showing involvement of right lobe with extension into left lobe and metastatic involvement of nodes. *(b)* Section showing spindle and giant cells (hematoxylin and eosin; magnification reduced from ×460).

who received what was thought by the surgeon to be curative surgical treatment have been evaluated.

Preoperatively, carcinoma was known or suspected in forty-seven (35 per cent) of these 136 cases. In an additional twenty-two (16 per cent), enlargement of cervical lymph nodes was noted clinically but no lesion could be palpated in the thyroid gland. In these cases carcinoma of the thyroid was one of the probable diagnoses. Exophthalmic goiter caused operation to be advised and carried out in fourteen cases; and in one of these the presence of a small nodule suspected of being a carcinoma was recorded preoperatively. In all fourteen patients the lesions were occult sclerosing carcinoma, and in none was there involvement of nodes. The histologic appearance of every lesion was identical with that of occult sclerosing carcinoma appearing in other thyroid glands. Fifty-three carcinomas were present in nodular or adenomatous goiters. Nine patients had clinical symptoms of hyperthyroidism and elevated basal metabolic rates.

harbored multicentric lesions, and in most of these instances lesions were present in both lobes of the thyroid gland.

Treatment of patients who had no metastasis to the lymph nodes consisted of lobectomy in thirty, double resection (lobectomy on the side of the lesion) in forty-one, and total thyroidectomy in one.

Methods for treatment of the primary lesion were much the same in cases in which cervical nodes were enlarged. In five of these cases radical neck dissection was done to remove extensive cervical metastatic lesions. One of the five had a modified neck dissection on the opposite side because of bilateral nodal involvement.

Fifty-nine patients had sixty-four modified neck dissections, five of them having bilateral procedures. The modified neck dissections varied considerably in extensiveness. In some patients only a group of nodes and adjacent fascia and fat were excised, while in others the dissection included all groups of nodes in the lateral and midline parts of the

neck, the procedure differing from a radical neck dissection only in that the internal jugular vein and sternocleidomastoid muscle were not sacrificed. In these cases not only the jugular chain of nodes (all levels) was involved, but also the nodes in the posterior cervical triangle, tracheo-esophageal groove, and laryngeal region.

Fifteen patients subsequently had a secondary operation in the lateral portion of the neck, usually the excision of a single node which was not always metastatically involved. Three patients had two such secondary procedures, one patient had three, and one patient had four.

There were no hospital deaths in the series.

The condition of 133 of the 136 patients was reviewed after five years: 129 were living, resulting in a survival rate of 97 per cent. In the ten-year period, 109 of 124 patients traced were alive, giving a survival rate of 88 per cent. In the fifteen-year period, forty-nine of fifty-seven patients were traced and thirty-seven (76 per cent) of the forty-nine were living. The average age for patients in this series was forty-two years. The five-year and ten-year survival rates compare favorably with those expected in the population at large at this age. The fifteen-year rate is slightly below the expected survival rate, but undoubtedly is related to other factors affecting longevity in older patients in the series.

Nineteen deaths are known to have occurred. Three resulted from recurrent carcinoma of the thyroid gland in the midportion of the neck. One patient also had pulmonary metastasis. In no instance in the series did carcinoma recur in the lateral portion of the neck. Two patients were known to be living with pulmonary metastasis ten years or more afterward. The cause of death of four patients is unknown, but must be presumed to be carcinoma of the thyroid. Twelve patients died of diseases unrelated to carcinoma of the thyroid. Eleven patients who had only biopsy because their lesions were inoperable are dead of carcinoma. Three are still living nine, ten, and eleven years after biopsy.

Comment

Slow Development and Surgical Conservation.—As a rule, carcinoma for which surgical treatment is indicated is best treated by as radical a surgical procedure as feasible to eradicate the primary lesion, as well as the primary region of spread. In surgery of the head and neck this rule holds true for squamous cell carcinomas and for most adenocarcinomas. However, papillary carcinoma of the thyroid gland is, in our opinion, an exception to this rule. It is a slow-growing lesion, and if the patient is treated surgically when the lesion is in an operable stage, the prognosis is excellent. Even for patients who have lesions that are inoperable and who undergo biopsy only or palliative resection, the period of survival is prolonged. Many of these patients live five, ten, or more years before dying of this disease. Distant metastatic lesions may be present for many years before causing death.

The usual course of untreated papillary carcinoma of the thyroid gland and the excellent survival rates illustrated in this series of cases have made us reaffirm our belief that patients having this disease do not always have to be subjected to radical operation. Although total thyroidectomy and radical neck dissection can be accomplished with a mortality rate of less than 1 per cent and with low morbidity, we consider it unwise, as well as unnecessary, to extend an operation beyond the limits that will offer the patient an excellent chance of survival and cure. Total thyroidectomy results in myxedema, a permanent disability but easily managed by replacement therapy. Total thyroidectomy further exposes the patient to parathyroid tetany, however, which is a severely incapacitating disease also requiring prolonged treatment. Martin has said that the seriousness of tetany has been overemphasized, but in our experience it has proved a serious handicap to the patient. Martin also stated that an attempt to save the parathyroid glands was relegated to a secondary, if not a relatively unimportant position at some hospitals. He believed that there is considerable security in the fact that accessory parathyroid glands frequently are present. Gilmour and Martin, however, have shown that in 88 per cent of the population there are only four parathyroid glands and in 6 per cent fewer than four. In treatment for other types of malignant disease, preservation of the parathyroid glands might be insignificant; but in the management of papillary carcinoma it is not. The glands can be identified, despite what has been said; and an attempt should be made to preserve some parathyroid tissue unless to do so would cause gross carcinoma not to be removed.

Multicentricity and Exploration.—Among the cases of papillary carcinoma in the series we have reported here, the lesions were multicentric in 11 per cent. In a subsequent study the incidence is 20 per cent. Consequently, the total thyroid gland should always be explored. Contrary to what has been said in the

literature, exploration of the thyroid gland does not jeopardize the success of subsequent dissection in the lateral portion of the neck, if such a procedure becomes necessary. Frequently the lesions are small and difficult to palpate. Because of the occurrence of multicentric lesions, lobectomy should be done on the side of the known lesion and subtotal lobectomy on the opposite side. Admittedly a small lesion could be left behind in the remnant, but this happening has been rare in our experience. When a small portion of thyroid tissue is preserved, the development of myxedema is usually prevented and parathyroid tissue and the recurrent laryngeal nerve on that side are further protected. There are those who advocate total thyroidectomy in all cases of carcinoma of the thyroid gland because of the high incidence of cases in which multicentric lesions are found, but on the basis of our experience in this series we cannot recommend this as a routine procedure. If at the time of operation, however, carcinoma is found to be extensive in the thyroid, or many lesions are found to be present in the gland, or distant metastatic lesions are known to be present, then total thyroidectomy should be done.

Metastasis.—In contrast to what has been stated by some, papillary metastatic lesions in the cervical lymph nodes remain well encapsulated for long periods. This fact makes the en bloc dissection of the lateral portion of the neck unnecessary for papillary carcinoma. Rarely, there is extensive involvement of all groups of cervical nodes, and standard radical neck dissection is the only practical method of removing the involved structures. However, if only one or a few of the groups of nodes are involved, then we believe a modified neck dissection will suffice.

The results of this approach are excellent, as illustrated in this series of cases. In no instance was there lack of control of the lesion by inadequate surgical maneuver in the lateral portion of the neck. In a small group of patients, previously mentioned, subsequent surgical procedures were necessary in the lateral portion of the neck either to excise another metastatic lesion or another node or to make certain that it was not involved. The occasional necessary excision of a node is less serious than routine performance of radical neck dissection in cases of lesions that can be treated by a lesser procedure and cases in which cervical nodes are clinically negative. One author who strongly advocates radical neck dissection for all cases of papillary carcinoma does a modified neck dissection on the opposite side of the neck when metastatic lesions are bilaterally present and admits that this is a satisfactory procedure.[16] Why then do a radical neck dissection in all cases?

The incidence of nodal metastasis in our series was 47.1 per cent. Others[6] have reported an incidence as high as 84.6 per cent. Undoubtedly our figure has been lowered by the long-time Mayo Clinic practice of advising thyroidectomy for many asymptomatic nodular goiters. As a result of this, many malignant lesions have been discovered surgically before metastasis had occurred.

Our practice is to do a neck procedure only when metastatic lesions are thought to be present and to extend the operation into the lateral portion of the neck only as dictated by the findings in this region in each case.

Occult Lesion.—Although occult papillary carcinomas of the thyroid gland have been included in the reported study, a separate study also has been made of 140 such lesions treated surgically at the Mayo Clinic over a thirty-year period. Fifty-eight were found because of the presence of nodal metastasis and the discovery of eighty-two was incidental to thyroid operations for other conditions.[18] Of the fifty-eight patients with nodal metastasis, four have died from causes unrelated to thyroid carcinoma and one patient is untraced. The remainder are alive, without evidence of carcinoma, three to thirty-two years after operation. Of eighty-two patients without metastasis, eleven are dead of known causes other than thyroid carcinoma. The remainder are living after periods ranging up to thirty years, and in none is either local or distant metastasis known to have developed. Histologically no clear-cut line could be drawn between those lesions associated with nodal metastasis and those discovered incidental to operations for a variety of thyroid disorders.

Other Categories

Follicular carcinoma of the thyroid gland—which, as mentioned, is seen in approximately 18 per cent of cases—usually remains well encapsulated. In contrast to the behavior of papillary carcinoma, its spread to the regional lymphatics is extremely infrequent. Hence, in carcinomas of this type, extending the surgical procedure to the lateral neck offers little added benefit to the patient unless there is gross or clinical evidence of spread to cervical nodes and an absence of known distant spread. Spread of this tumor is largely blood-borne and death occurs mostly

from metastasis to lungs or bone. Follicular carcinoma frequently shows evidence of function, especially in the absence of normal thyroid tissue; and because of this, metastatic lesions of this tumor can be treated by radioactive iodine. Total lobectomy on the side of the lesion and subtotal lobectomy on the opposite side are done for these lesions. However, if distant metastasis is known or thought to have occurred, then total thyroidectomy is indicated in patients with these lesions, since it not only eliminates the primary tumor but also the remaining normal thyroid tissue and prepares the patient better for radioactive-iodine therapy. Total surgical thyroidectomy is preferred to medical thyroidectomy because it permits the maximal allowable radiation to be used in the treatment of the metastatic lesions. The over-all survival rates of patients with these lesions have been good.

Seventy per cent of these lesions take up significant amounts of I^{131} with clinical improvement of the patient. In about 50 per cent of cases the metastatic lesions appear to have been arrested if not cured by radioactive iodine.

Solid carcinoma occurring in approximately 6 per cent of cases is circumscribed but unencapsulated. It spreads to the regional lymphatics in more than 50 per cent of cases. Even though its growth is slow, its clinical behavior is more aggressive. Recurrence of the tumor appears in the midline of the neck and distally. Often when this lesion is identified at surgery, total thyroidectomy should be done. The precedure should be extended into the lateral neck, depending upon clinical and gross findings. Death results from this carcinoma in approximately 33 per cent of cases.

Anaplastic carcinoma, accounting for 15 per cent of lesions of the thyroid gland, entails a very poor prognosis. The lesion grows rapidly and is invasive, involving other midline structures of the neck such as the trachea and esophagus. Usually when first seen by the surgeon it already extends into the lateral aspects of the neck and into the mediastinum and presents an almost hopeless situation. Very often it is possible only to establish the diagnosis by biopsy and perform a tracheotomy to assure a satisfactory airway. External radiation therapy may be of some palliative value and should be recommended. Occasionally the surgeon encounters an early lesion; and in such a case a total thyroidectomy should be done, with excision of adjacent and overlying strap muscles. Because of the poor results in the treatment of anaplastic carcinoma we have been hesitant to suggest and do a radical resection of the anterior compartment of the neck. However, if the lesion is still localized to the thyroid region, this procedure might cure the patient. But even though an adequate operation is done in the neck, distant metastatic lesions almost always appear in a few months. Fewer than 10 per cent of the patients survive this disease, the others dying from it in six to twelve months from the time of the diagnosis.[10]

Conclusions

From this discussion it should be apparent that it is extremely important that malignant lesions be properly identified histopathologically at the time surgical treatment is instituted. Since the degree of malignancy and the behavior pattern vary considerably from one lesion to another, the surgeon, by knowing the type of tumor that he is dealing with, can be more selective in deciding the extensiveness of the surgical procedure that he carries out. It is essential that histopathologic interpretation by fresh frozen section technique be available. Although it has been said that thyroid lesions can be identified only as benign or malignant by this method, it has been our experience that a surgical pathologist well trained in thyroid disease can determine from frozen sections very accurately not only whether a lesion is benign or malignant but also the histologic type of the neoplasm.

It seems wisest to extend an operation only to the limits that offer the patient the best chance of cure as indicated by the information available. Most often thyroidal lesions of low malignancy can be managed by conservative surgical procedures. The results are excellent in most such cases. On the other hand, lesions of high degrees of malignancy rarely are treated successfully by surgical or other measures, and prognosis in these cases is very poor.

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The Radiotherapist and Breast Cancer

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CHEMICALS, hormones, irradiation and surgery are all used in the treatment of cancer. Each of these can be employed alone or in various combinations. Physicians should understand the principles and limitations of treatment by the various modalities. I will outline the principles of radiation therapy in cancer by illustrating their application in the treatment of breast cancer.

The radiation therapist seldom has sole responsibility for a cancer patient, especially in cancer of the breast. His role varies according to the particular need in each patient. The following steps are essential to the proper handling of a case: (1) An accurate diagnosis must be made. (2) An evaluation of the general physical condition of the patient and the extent of her disease must be determined. (3) Finally, appropriate therapy must be planned and executed.

This may require the participation of the family physician, pathologist, surgeon, internist, chemotherapist, and radiotherapist. The need for skill and ingenuity may be even greater when cure cannot be expected. The inoperable patient presents a challenge for continued and effective palliation. The participation of several physicians need not lead to confusion, but rather should enhance the welfare of the patient.

Once the diagnosis of breast cancer is made, determination of the extent or the clinical stage of the disease is of paramount importance. The histologic grading of the tumor is of secondary consideration. A number of questions present themselves. Is the malignant process local or has it spread? Is the spread locally infiltrative, regional, or are inaccessible nodes involved? If spread is distant, is it local or generalized? The answers to these perplexing questions are the guideposts of a well planned therapy program. Clinical staging indicates whether curative or palliative treatment is feasible. Staging should be done even though subsequent findings may show the initial evaluation to have been in error.

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If a malignant tumor has spread, destruction of the local growth rarely results in cure. Conversely, if it is localized, destruction of this local growth usually does produce a cure. Subjecting breast cancer patients to ill advised or impetuous treatment may interdict an otherwise favorable prognosis. Each patient deserves tempered consideration, detailed study, and consummate skill. This is especially true in the early stages of the disease when the chance for cure is greatest. The golden opportunity is in the initial treatment period. The most valuable consultation may be the one held before the first incision is made.

Irradiation was used in the treatment of breast cancer within a year following Roentgen's initial report on x-ray. It has played an increasingly important role in therapy since that time. McWhirter of Edinburgh and Baclesse of Paris, have done much to promote continued interest in x-ray therapy for breast cancer. Its clinical uses are varied. Preoperative therapy is of value in some instances. It is administered most often following radical mastectomy and occasionally after super-radical operations. Combination of radiotherapy and limited surgery is an accepted program. Radiation therapy as the primary method of treatment is widely employed for unresectable local disease. It has application in palliative treatment of metastatic disease and in achieving castration.

A reference to the biological and physical factors of irradiation seems in order before further discussion of its application in the treatment of cancer. All living cells can be destroyed if exposed to sufficient irradiation. The amount required varies according to the cell and its matrix. Most cancer cells are more sensitive to irradiation than normal cells. Measured amounts of irradiation that will destroy cancer cells will only damage normal cells. Damaged cells can recover and permit healing to occur. Several factors make it difficult to attain this desired result. A lethal level of irradiation must be delivered to the malignant cells. Normal skin, intervening tissue, and vital structures adjacent to the malignant tumor must be spared irreparable damage. Several techniques are used to

accomplish this, taking cognizance of beam, field, time, and dose factors.

Skin and subcutaneous tissue are spared by directing the beam through multiple skin fields. Rotational therapy accomplishes this most effectively, but unfortunately it cannot be used in treating breast cancer. The axillary contents can be treated through anterior, posterior, and intra-axillary fields. Thus, the required total entry dose can be divided proportionately among three treatment fields. A second sparing effect is obtained through choice of the therapy beam. Higher energy level beams produce less damage to superficial tissue per unit of radiation delivered at a given depth. The beam from a 400 kilovolt apparatus provokes less skin reaction and delivers a greater depth dose than a beam from a 180 kilovolt machine. This illustrates the value of more powerful equipment in treating deep-seated lesions.

Normal cells recover from exposure to irradiation faster and to a greater degree than cancer cells. This recovery rate differential is exploited to spare normal cells from lethal damage. The therapist controls both the time between treatments and the time over which a treatment series extends. A saturation level of irradiation damage is induced, maintained, and enhanced by multiple sublethal exposures until cancer cell death ensues.

The expression "lethal tumor dose" has little meaning by itself. Actual doses required to destroy cancer cells may range from as little as 3000 r. to more than 7000 r. A clinically intended dosage is derived after considering pertinent treatment and patient factors. Treatment factors have been indicated. Patient factors include the person's age, and type, site, volume, and the rate of growth of the tumor.

Therapy Programs

Certain observations should be made before surgical or radiation therapy or both are undertaken. A careful non-traumatic examination of the breasts, the axillae, and the tumor is conducted. The size, site, and degree of infiltration of the growth is noted. A chest x-ray is taken. A bone survey, marrow aspirates, and serum electrophoretic studies may be done. These help avoid radical surgery when distant disease is demonstrable. A single or multiple site biopsy is taken to permit clinical staging of the disease. If the extent of disease is within limits of resectability and the surgeon feels no disease was left behind, irradiation therapy will not be required. Other surgeons consider an oversight in the detection of residual disease to be possible and request postoperative x-ray treatment for their patients. In this instance therapy is directed to the internal mammary, supraclavicular, and axillary lymph node areas. Treatment to these areas includes possible implants in fat, subcutaneous tissue, and skin. The chest wall is treated if it is believed there is residual neoplastic infiltrate here.

We usually select a conventional or orthovoltage technique and standard treatment fields and distances for these cases. Treatment is given until the desired depth dose is attained. This may be 4200 r. to the axillary, 4500 r. to the supraclavicular, and 3700 r. to the internal mammary node areas. The factors are altered if treatment must be given over the chest wall. Here we reduce the energy level of the beam and treatment distance and cross-fire as tangentially as possible. This reduces irradiation hazard to underlying lung tissue and allows delivery of 3800 r. to 4200 r. to the chest wall. The head of the humerus is shielded to protect it from unnecessary irradiation.

The patient feels nothing during actual treatment. Time per treatment may be as short as four or as long as fifteen minutes. Treatments are given five or six days a week. A short rest period of several days midway in the series may be given.

If the surgeon subscribes to the so-called McWhirter concept of treatment, a simple mastectomy is done. The operation should remove the primary tumor, although residual tumor may be present in the tumor bed, regional nodes, and sternal marrow. Treatment is essentially as outlined above, except that the chest wall is always treated in these instances. The series takes slightly longer and the probable metastatic sites may be given an additional 800 r. to 1200 r. It should be noted that the McWhirter technique calls for a radical operation in selected patients.

If a patient is unable to withstand extensive surgery, or if disease is unresectable, the primary therapy becomes irradiation. Breast tumor and a varying amount of breast tissue may be removed. This avoids the need of intensive irradiation of a bulky primary tumor mass and the possibility of scattering irradiation from the mass to underlying lung. Limited mastectomy is contraindicated if there are inflammatory changes, ulceration, or gross involvement of the tumor pedicle. An extensive treatment program, which extends over three to four months, is prescribed for these patients. Five or six standard treatment fields are required. Additional fields may be employed according to the extent of the disease and the surgery performed. Treatment is given to attain such doses as 6000 r. to the supraclavicular nodes, 6500 r. to the axillary contents, 4200 r. to the internal mammary

nodes, 7000 r. to the primary lesion, or 4200 r. to the chest wall if a limited mastectomy was done. Chemicals, hormones, and castration may be combined with the irradiation therapy. These patients tolerate their program remarkably well. Ulcerations heal, regional nodes become nonpalpable, arm edema subsides, the patients put on weight and gain hope.

Extramammary Treatment

Effective x-ray castration can be accomplished with little morbidity. The dose should be sufficient to make cessation of the menses permanent. This may require from one to three weeks of treatment, depending upon the age of the patient. The younger the patient, the larger the dose required. The patient may have one or even two periods after the castration series is started. The patient must be so advised.

Local recurrences of lesions in skin, bone, and glands can be treated with x-ray. Skin lesions are treated essentially as other forms of skin cancer. There is a limit to the amount of involved skin that can be treated.

Local bone metastases usually become relatively asymptomatic several weeks after delivery of a tumor dose of 2800 r. to 3600 r. A combination of radiophosphorus and male hormone often relieves the devastating pain of multiple bone metastases for several months.

The treatment of regional node recurrences can be accomplished without causing necrosis of overlying skin and subcutaneous tissue if special attention is given to skin-sparing factors.

Reactions

Most patients and many physicians have misconceptions about radiotherapy reactions. The reactions are usually anticipated and controlled. Their occurrence is not a valid contraindication to therapy. The referring physician helps immeasurably if he speaks enthusiastically about the treatment and does not refer to, or minimizes, any discussion of reaction. The therapist will discuss these with the patient initially and as treatment progresses.

Nausea is the reaction most often feared. If nausea develops, it is usually mild and controlled easily with available medicines. It seldom dictates interruption of a treatment series. Vomiting is uncommon.

These patients develop skin erythema in the treatment sites. The degree of reaction varies. A faint blush or tan is seen with full radioactive cobalt doses. A moist desquamation may occur in intertriginous and cross-fire areas in orthovoltage programs. A deep and long-lasting pigmentation occurs in the intensive series given inoperable cases. Erythroderma is slight or absent in the treatment of bone metastases and in castration techniques. Brisk reactions are necessarily induced in the treatment of skin and lymph node metastases. Skin reactions rarely become a real problem to the patient or the therapist. Erythroderma is an indication of an effective level of irradiation. The delivery of such a level is required if treatment is to be given.

Many physicians hesitate to request irradiation therapy in breast cancer for fear of post-irradiation pneumonitis and lung fibrosis. The upper one-third of the lung is caught in a cross-fire of irradiation and frequently develops inflammatory changes. Other areas of the lung commonly do not receive sufficient irradiation to have such changes evolve. Tangential ports, short treatment distances, and a soft beam are employed for their lung-sparing effect. The pneumonitis that does occur may be asymptomatic, and clear in three or four months. Perhaps half of the patients develop a degree of fibrosis in four to six months. This is usually confined to the apex, and rarely does this (or even greater) involvement cause incapacitation. The probability of metastatic pulmonary disease must be considered where extensive late changes develop.

Less common untoward reactions are bone fracture, leukopenia, lassitude, and inanition. These are usually avoided by skillfully administered therapy which includes rest periods and supportive measures for the patient, when indicated.

Equipment

A final word about equipment is in order. Orthovoltage and supervoltage x-rays and the gamma rays from radioactive cobalt do not differ greatly. Unit for unit the orthovoltage beam causes greater skin reaction and has less body penetration than the other beams. Unit for unit the orthovoltage beam has greater biologic effect on the cells in the treatment area. Orthovoltage beam techniques are effective and good. The higher energy beams are used to advantage in given situations. The equipment is said to constitute a ten per cent factor in the effectiveness of treatment. The important ninety per cent factor is the skill with which the therapist utilizes the modalities at his command.

Diagnosis of Tumors of the Breast

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THERE ARE no new methods for either diagnosis or definitive treatment of lesions of the breast. In spite of countless and ever-increasing end-result statistics, diagnosis is still a major problem. Frequently, various and differing opinions are given about the same lesion. Accordingly, it was thought that a review of personal experience, although the total number of cases is not great, would be rewarding.

This is an analysis of 119 consecutive breast lesions seen in our office during the six months ending June 30, 1960. The distribution of the lesions by type is given in Table I. It is evident that today in an average surgical practice only a small proportion (8 per cent) proved to have cancer.*

TABLE I. DISTRIBUTION OF BREAST LESIONS BY TYPE

	Cases
I. Fibrocystic Disease	102
(Average age 39 years)	
II. Negative Examinations	4
III. Other Breast Lesions	4
IV. Carcinoma	9
(Average age 46 years)	
Total	119

A personal tabulation in 1949 of tumors of the breast indicated that even then a decrease in the incidence of malignant breast tumors was evident.[1] In 1943, 50 per cent of breast tumors seen were carcinoma. In 1947, 30 per cent were carcinoma. That trend has continued. As examination was negative in four patients, and the other four lesions found (breast abscess, lipoma, fatty infiltration, accessory breast tissue) presented only minor questions, the large diagnostic problems of 1960 seem to center on fibrocystic disease (102 patients), and cancer (nine patients) [Table I].

As one sees these patients, the major diagnostic problems are:

1. (a) when should fibrocystic disease be operated upon; (b) when should it be observed; (c) when can a cyst be recognized and aspirated by a simple procedure; and

2. (a) how does one recognize the 8 or 9 per cent of patients who have definite carcinoma, or (b) are of such nature that diagnosis is uncertain? These patients must be informed that operation is necessary for diagnosis.

Observations concerning diagnosis in breast lesions follow the categories established in Table I.

Fibrocystic Disease

Our 1960 experience with the 102 patients having fibrocystic disease is summarized in Table II.

No Surgery.—Twenty-three (22 per cent) patients were advised not to have operations during this six-month period. Some had been advised previously to have surgery—often with the suggestion that it was urgent. All were apprehensive. The physician must appreciate a woman's attitude toward the possibility of losing the breast, an attitude which is often irrational to the point of hysteria, before he gives any advice to the patient.

(1) In seven patients no mass, or an indistinct mass was felt. We reassured them and discharged them

*Comparable figures at the time of operation show: Sinai Hospital 15 per cent, and Harper Hospital 16 per cent carcinoma. This is a different statistic. Cases for which nothing should be done are screened out by office examination.



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Dr. Robert Allaben (Resident in Surgery, Harper Hospital) and Dr. Paul Neufeld (Resident in Surgery, Sinai Hospital) assisted in this study.

from observations. (2) We thought fifteen patients had distinct masses, but did not suggest operation. This decision involves calculated risk and should be checked by follow-up observation. Five of these fifteen patients are still being followed two to thirteen months after their first visits. Four who did not keep their follow-up appointments were called back for another examination; three were told to return to the referring doctor, and he was again contacted. None of these twelve patients has yet needed operation. Two patients were discharged from follow-up and one left town. (3) One patient observed repeatedly over several months showed no change. (4) Four patients, asked to return, did not do so. Follow-up revealed they were all operated upon elsewhere within one month. Three had benign tumors. One had complete mastectomy. At her second visit she was told definitely that the mass should be removed. (It was learned subsequently that this had proved to be carcinoma.)

Thus, except for one of the patients who went elsewhere, our original opinion that conservative measures were most appropriate for these patients was confirmed by follow-up.

First Surgery Within Two Months of First Visit.—Among the thirty patients who had surgery within two months of their initial visit, three required only simple aspiration (an office procedure, but classified as surgery in this study); one of these three was lost to follow-up after a single return visit had revealed no recurrent cysts. The other two have been followed for two and five months. There are no further positive findings.

In twenty-seven cases, the breast mass was locally excised within two months of the first visit. In retrospect of the eight masses which proved to be large cysts, some might have been aspirated, which would have let the patient avoid a general anesthetic, as well as the operative and emotional trauma of breast surgery. Our policy has been to aspirate a cyst in the office only if palpation reveals a ballotable fluid wave. Sometimes the fluid is under considerable tension, and the mass feels solid, not fluctuant. When one suspects this situation, the patient may be sent to the hospital and prepared for operation. If aspiration reveals fluid, usually nothing further is done. A week's delay may make the presence of fluid more certain because tenseness subsides after the initial filling.

The other nineteen patients proved to have the usual fibrocystic disease.

TABLE II

	Cases
No Surgery—27	
1. No mass or indistinct mass	7
2. Mass	15
3. Repeated observation	1
4. Surgery advised, patient did not return	4
First Surgery—within two months of first visit—30	
1. Aspiration	3
2. Local Excision	27
First Surgery—more than two months after first visit—6	
1. Aspiration	0
2. Local Excision	6
Surgery for Recurrent Disease—27	
1. Repeated aspirations	8
2. Repeated aspirations/surgery	19
Nipple Discharge	5
Fibroadenoma	7
Total	102

First Surgery More Than Two Months After First Visit.—Six patients with pathologically confirmed fibrocystic disease had local excision more than two months after they were first seen. In no case was the delay regretted. The longest period before surgery was three and one-half years. In this instance, operation finally was done to assuage the patient's constant fear that she had cancer.

Surgery For Recurrent Disease.—Fibrocystic disease can persist a long time. It may progress slowly as the patient approaches her forties; it may remain stationary, or it may regress. Cysts may form, become tense to palpation, and then subside. Local areas may become more solid to palpation. It is unfortunate that this palpatory perception often is the only criterion upon which one bases his decision to operate. Certainly the mere presence of fibrocystic disease, even though it has existed for years, does not make operation necessary. In this group, twenty-seven patients had repeated surgery for fibrocystic disease. Eight patients had only repeated aspirations, all performed in the office.* One patient was aspirated nineteen times in seven years. Nineteen patients had repeated aspirations, local excisions, further aspirations, then excisions again over periods of one to fourteen years.** No patient had

*The number of aspirations ranged from: 2-4 times (4 patients); 5 times (2 patients, over 4 and 9-year periods, respectively); 11 times (1 patient over 7-year period); and 19 times (1 patient over 7-year period). Both of the last two patients were in perfect health when last seen.

**Eight (followed 1 to 5 years) had 17 aspirations and 13 local excisions. Six (followed 6 to 10 years) had 19 aspirations and 13 local excisions. Five (followed 11 to 14 years) had 9 aspirations and 10 local excisions.

TABLE III. TIME OF DISCOVERY AND SIZE OF TWENTY-SEVEN CONSECUTIVE BREAST CARCINOMAS (1959-1960)

Lump Discovered	*Cases*	
At routine physical examination	5	
24 hours before examination	2	
Two weeks before examination	11	
One month before examination	1	
		19
Six months before examination	3	
One year before examination	3	
Two years before examination	2	
		8
Total		27
Size of Lesion		
Under 1 cm.	3	
1 cm. to 1.9 cm.	9	
2 cm. to 2.9 cm.	6	
3 cm. to 3.9 cm.	6	
4 cm. or less		24
4 cm. to 4.9 cm.	1	
5 cm. to 5.9 cm.	1	
4 cm. or more		2
Not listed		1
Total		27

more than three local excisions. Within six years, one patient had ten aspirations and two local excisions. Another, followed for twelve years, had five aspirations and two local excisions. In these twenty-seven patients, fibrocystic disease was the only diagnosis entertained. In none did cancer develop in the follow-up period.

Nipple Discharge.—Five patients presented only nipple discharge. One was observed for two and another for nine years before drainage stopped spontaneously. In two patients, a duct papilloma was excised. The fifth patient had two biopsies done two months apart for serous discharge from the nipple; the pathologic diagnoses were fibroadenoma and fibrocystic disease with duct ectasia.

Fibroadenoma.—Patients operated upon for fibroadenoma usually are younger than those with other breast lesions. The average age of the seven patients in our series was twenty-seven years. Six were operated upon after the first or second office visit. The other patient had a small (1.5-cm.) tumor which was removed after a seven-month period of observation.

Negative Examination

Four patients had no disease of the breast. Three of these had experienced pain in or near the breast. In the fourth, a breast mass had been discovered by her physician. At our examination a day later no mass could be found, and a second examination three months later still did not show breast disease.

Other Breast Lesions

Four patients were operated upon for other miscellaneous breast lesions. In three, histologic diagnoses were lipoma, accessory breast, and fatty infiltration; the fourth was an abscess which was drained by incision.

Carcinoma

In this group of 119 patients seen during the first six months of 1960, nine carcinomas were found. To obtain a better indication of whether our policy of not operating upon all breast lumps was causing delay, detrimental if cancer existed, the series was enlarged to include all patients with breast cancer seen in 1959. During this period, eighteen were seen, making a total of twenty-seven consecutive patients for analysis. Their average age was forty-six years, as contrasted with the average of thirty-nine for patients with chronic cystic mastitis.

Table III shows that most lesions were of short duration and were small. Two-thirds had been noticed for one month or less, and only two were larger than 4 cm. In our experience, the type of breast cancer most frequently encountered is changing. More and more in private surgical practice, the major problem is not what to do with an extensive typical carcinoma, but it is the differential diagnosis of small breast lesions with short clinical histories.

Twenty patients were operated upon immediately. Operation on seven patients was delayed for various reasons. These represent the crux of the problem, and their subsequent management is therefore described in detail. In three of the seven patients surgery was delayed because cysts were suspected, and the lesions were aspirated. One unsatisfactory aspiration was immediately followed by surgery. Another patient was asked to return in two weeks but did not do so for eight months. Even then the mass was only 1 cm. in diameter. Aspiration of the third patient's lesion yielded 0.5 ml. of clear fluid. The patient, an apprehensive woman horror-struck over the possibility of losing her breast, had had bilateral mammeloplasties with insertion of ivalon sponges six years before. Partly because of this, the

decision was made to follow her at bi-weekly or monthly intervals. After four months, a minute (0.5-cm.) firm mass was still palpable. Exploration at this time disclosed carcinoma.

In another, a small mass in the upper outer quadrant was watched until it almost disappeared. Two months later a second, entirely distinct hard mass, was found in the lower half of the breast. Immediate operation was done. The other three patients were told to come back for a second examination within one month and did so. All three were then promptly operated upon and in each a small lesion was found; the delay of one month was apparently not harmful.

The diagnosis of cancer was confirmed in each of these twenty-seven patients. Though the preoperative diagnoses were: benign, seven; malignant, twelve; and undetermined, seven, the indications for surgery were clear. The crucial point is that the urgent need for operation or frequent observation was recognized. Among the twenty-seven patients, twenty were operated upon immediately, one without delay after aspiration, three after one month follow-up, one after two months, and one after four months of close supervision. Only one patient failed to return in two weeks as requested.

The calculated risk is: Will the patient return for follow-up observation *as directed*? In this group only one did not do so.

Diagnosis

The diagnosis of small breast lesions (1-2 cm.) demands a degree of expertness, but it is not time-consuming. There are no elaborate diagnostic tests upon which one can rely; radiographs are not helpful. A history of a mass that has appeared suddenly, accompanied by localized discomfort which perhaps abates after forty-eight hours, indicates the presence of a benign cyst. Age is of considerable importance. Fibroadenomas are more common in women before or in the thirties. Fibrocystic disease is more common in the late thirties and early forties age group; only six of the 102 lesions reviewed in this paper occurred in women fifty years or older. The tense, frequently childless, thin-breasted woman who may tend to have thyroid or ovarian disturbances, is *the* candidate for fibrocystic mastitis.

Close inspection with the patient in various positions (sitting up, reclining, bending over, bending forward, arm raised, turned to opposite side) may reveal a small area of skin dimpling if the tumor is superficial. Slight skin retraction in the region of the nipple and areola may be due to fibrocystic disease in the terminal ducts. Here secretions are more inspissated, and infection of various degrees may supervene. Plasma cell mastitis near the nipple may mimic fibrocystic disease.

Beyond inspection, the diagnosis must be made by two-finger palpation. It avails little to grasp the whole breast in one's hand. The most information, in our experience, is obtained when both patient and doctor are in a relaxed position. The backrest of the examining table is raised twelve inches, so the patient's torso is slightly elevated and the breasts fall dependent. The examiner sits comfortably on a stool adjusted so that the hands and elbows are easily level with the breast to be examined. The breast is shifted so that the involved area can be palpated against the chest wall. Then light, gentle finger palpation, preferably between the index fingers of the right and left hands, provides the most information. Vague fullness, a slight localized edema or engorgement will be appreciated. A cyst less than 0.5 cm. in diameter can be discerned by its tenseness. A larger cyst (1-2 cm.) may at first give the impression of hardness, but careful palpation, perhaps repeated after a few minutes rest, may reveal the true nature of the lesion. A larger, more deeply situated, undistended cyst may be missed unless the breast, especially the outer portion, is surveyed carefully in this manner. The aspiration of what was considered one cyst may disclose as a residual the presence of another contiguous one.

The edge of a solid tumor can give the impression of a sharply receding ledge, indistinctly fading into the surrounding breast tissue; or irregular lumpiness may be felt. It is in lesions of this type that a second and even third examination after one to two week intervals are very rewarding. The risk is that the patient may not appear at the time she is asked to return. The follow-up must be very positive. We do not believe a delay of treatment of two or three weeks alters the prognosis for early cancer. We have observed the disappearance of lesions between the time of diagnosis and admission to the hospital a week later.

Discussion

In our experience with 119 consecutive patients with breast lesions, 102 had fibrocystic disease.* The findings in eight patients were negative or presented

*See Table II, *No Surgery*, Item 4, "Surgery advised, patient did not return." It was subsequently learned that one of these patients was operated upon elsewhere and the lesion proved to be cancer.

only minor diagnostic problems. Nine patients (8 per cent) had cancer.

Of the 102 patients with fibrocystic disease, twenty-three (22 per cent) were reassured and nothing further was done. Follow-up revealed no basis for regretting the decision to delay treatment.

In three patients, office aspiration of breast cyst was done at the time of first examination or within two weeks. In eight instances, local excision revealed a solitary cyst.

Eight patients had only repeated aspirations; two had eleven and nineteen aspirations, respectively, in seven years. Twenty-seven patients had repeated local excisions and aspirations over periods varying from one to fourteen years. None gave cause to regret this conservative management.

The steady decrease in the proportion of breast lumps seen which are cancer, as well as the small size of today's typical breast tumor, indicate steady improvement in the promptness with which women seek medical advice.

Of twenty-seven consecutive breast cancers seen in private practice, five were discovered during routine physical examination, and fourteen were noticed by the patient one month or less before examination. All but two of the lesions were less than 4 cm. in diameter.

A policy of deliberately observing breast lesions when there is not clear indication for surgery must take into account the calculated risk of delaying an operation which might reveal unsuspected cancer. Among the twenty-seven patients who ultimately proved to have breast cancer, risk was small although not all of the cancers were diagnosed preoperatively. The urgency of operation was recognized in twenty-five cases, and the necessity for close follow-up in the remaining two.

Summary and Conclusions

1. Breast lesions are now being seen in private practice early in their development. In this series, most cancers were less than 4 cm. in diameter and had been noticed for one month or less.

2. Cancer represents, in our experience, less than 10 per cent of all breast lesions.

3. Of 102 cases of fibrocystic disease, twenty-three (22 per cent) required no treatment and eleven (11 per cent) required only simple aspirations.

4. The indication for careful observation of certain breast lesions and the potential danger in delayed operation for the patient with suspected or unsuspected cancer are discussed.

Reference

1. Saltzstein, H. C. and Pollack, R. S.: Benign tumors of the breast. J.A.M.A., 140:997, 1949.

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Scleral Tonometry

An instrument intended to be used, by application to the sclera, to measure intraocular pressure has been available on the market and is apparently being used by some optometrists with the belief that the instrument will detect glaucoma. The matter is of interest to optometrists since the instrument is offered for use without local anesthetic (not legally available to optometrists), and it is apparently believed by some that the procedure is within the province of optometry if drops are not used.

An evaluation of the instrument has recently been published. In the *American Journal of Ophthalmology*, 49:355 (1960), Havener and Patterson reported on 219 eyes, 70 of which had elevated intraocular pressure at the time of measurement. The Wolfe scleral tonometer failed to detect elevated pressure in 82 per cent of the 70 eyes with known glaucoma. It gave false high readings in 22 per cent of eyes with normal intraocular pressure.

The Wolfe tonometer obviously is not reliable enough to be of any practical use even in the hands of persons legally and educationally qualified to practice pathological diagnosis. This is not the first time scleral tonometers have been found unsatisfactory.

Previously work at the University of Michigan by Hogg et al had shown the Wolfe scleral tonometer to be unreliable, the unreliability being greater in the high levels of tension.—*News Bulletin*, Foundation for Eye Care, February, 1961.

Carcinoma of the Vulva

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PRIMARY CYSTS and neoplasms of the vulva comprise a heterogeneous collection of lesions. However, there is one group of tumors which is of major significance: malignant neoplasms of epithelial origin, or the carcinomas. It is towards these, which comprise 5 per cent of all malignant tumors of the female genital tract, that attention is directed. This is done for the purpose of elucidating some of the aspects of their natural history, and hence clarification of their treatment.

The final diagnosis of a vulvar lesion should always be made by biopsy and it is frequently necessary to remove tissue from several different areas in order to properly assess its nature and extent. There is a tendency for patients with vulvar carcinoma to delay seeking medical advice and for the physician to delay making a definitive diagnosis; *patient delay* and *physician delay* for vulvar carcinoma are much greater than for many other forms of cancer. *Patient delay* can frequently be attributed to a mid-Victorian aversion to examination of the genitalia. *Physician delay* is due to a tendency to consider vulvar carcinoma as a disease restricted to the sixth and seventh decades, a tendency to regard slow progression of the disease as evidence of absolute benignancy, and an unexplained reluctance to biopsy vulvar tissue which, grossly, is not highly suggestive of carcinoma. These delay periods can be reduced only by the education of patients to accept and to demand complete examination, and by stressing the value of biopsy of all vulvar lesions without delay.

During the twenty-five-year period 1932 to 1956, inclusive, tissue from 719 primary neoplasms and cysts of the vulva was submitted by the Department of Obstetrics and Gynecology for examination by the Department of Pathology at The University of Michigan Medical Center. One hundred and ninety-nine lesions were malignant (Table I), and 186 of these were of epithelial origin, namely, carcinoma. The remaining thirteen cases were sarcomas and melanoblastomas. The latter are considered by many to be of epithelial origin but were not so classified in this study.

TABLE I. PRIMARY NEOPLASMS AND CYSTS OF THE VULVA

Type of Tumor	Total
All primary cysts and neoplasms	719
Cysts	145
Neoplasms	574
Malignant neoplasms	199
Malignant epithelial neoplasms (carcinomas)	186

Classification of the various types of carcinoma of vulva that are encountered and the numbers of the different types which we have encountered during the selected period are given in Table II. Ten per cent of the lesions were intra-epithelial or *in situ* in nature. These possessed all the cytologic features of carcinoma. There was no extension of the neoplastic process beyond the epidermis, squamous mucosa, or the epidermal appendages. Not all forms of intra-epithelial *(in situ)* carcinoma of vulva are histologically and clinically the same, and three distinctive types of histologic lesions can be recognized.

Intraepithelial Squamous Cell Carcinoma

Simplex-Type.—This is probably the least distinctive and the least readily recognized form of carcinoma *in situ*. It is distinctly different from Bowen's or Paget's disease and is usually observed in association with leukoplakic vulvitis. Squamous cells of the

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involved area are well differentiated although atypical, possess hyperchromatic nuclei, and frequent division figures (Fig. 1). The neoplastic cells do not extend in all instances throughout the entire thickness of the squamous epithelium. The histologic changes are subtle and difficult, if not in some instances impossible, to distinguish from pseudoepitheliomatous hyperplasia. This form of carcinoma can be diagnosed only by multiple biopsies of an area which clinically presents the features of leukoplakic vulvitis.

Bowen's Type.—The concept that Bowen's disease is a premalignant dermatosis is no longer valid, and it is accepted as a distinctive clinical and histologic form of carcinoma which exists in a non-invasive or intra-epithelial phase, frequently for long periods, after which it becomes invasive and may metastasize. Eleven per cent of all squamous cell carcinomas of vulva reviewed by Abell and Gosling[1] were considered to be of Bowen's type.

The majority of patients with Bowen's disease are much younger than those with other forms of vulvar carcinoma, the average age being forty-three years. There is a higher incidence of Negro patients and of pre-existing vulvar granulomas than encountered for other types of vulvar carcinoma. Pruritus is the most frequent complaint. The disease involves the labium majus and labium minus with about equal frequency and in 50 per cent of our cases there were two or more separate foci of involvement. The lesions grossly appear as thickened, slightly elevated, crusted patches or plaques that have sharp serpiginous margins. Sometimes they have a flat verrucal configuration and multiple superficial ulcers may be present. When the crusts and keratotic flakes are removed, the surfaces are dull red and moist. The involved areas of moist squamous mucosa present a granular dull-red appearance.

The histologic features of Bowen's disease are distinctive and show wide, often multicentric, areas of involvement of epidermis, or mucosa, or both. There is thickening of the involved squamous epithelium with patchy hyper-keratosis and para-keratosis. The normal stratification of cells is lost and the epithelium may be thrown into verrucal folds. Many of the nuclei are irregular in contour, hyperchromatic, and division figures (including abnormal forms) are frequent (Fig. 2). Corps ronds, abnormal grains, multinucleated giant cells, and micropearls are other features of the neoplastic change. Vulvar recurrences appeared in six patients and in one of these, metastases to regional lymph nodes occurred. In two instances the recurrences consisted of *in situ* carcinomatous changes in vaginal and anal mucosa.

An important observation is the association of other primary malignant neoplasms in patients with Bowen's disease (37.5 per cent as compared to 1.5 per cent for the usual form of epidermoid carcinoma of the vulva[1]). In the majority of these cases, the other primary lesions were in the uterine cervix suggesting a common reactive field to either hormonal or infective agents, or both. Woodruff and Hildebrandt[2] also noted an increased incidence of carcinoma of the uterine cervix in association with Bowen's disease of the vulva. Although histologically the lesions of Bowen's disease have a wild cytologic picture with many bizarre cells, frequent division figures and tumor giant cells, survival ratios, even with associated infiltrative growth, are much better than those of the less bizarre type of epidermoid carcinoma. Only in one of the cases of Bowen's disease was death attributed to the carcinoma.

Paget's Type.—Extramammary Paget's disease of the vulva is a rare lesion which has been accorded much more recognition than its incidence justifies. It has at times been confused with Bowen's disease and with achromatic melanoblastoma. The disease exists in two phases: an intra-epithelial phase and an infiltrative phase. The neoplasm appears to arise from cells in the epidermis that still possess the ability to produce a mucinous material and from cells in the apocrine sweat glands.[3-7] Infiltration of the dermis may subsequently proceed from foci of neoplasm within the epidermis, or from foci within the sweat glands.

The majority of the patients with Paget's disease of the vulva are over sixty years of age, frequently in the seventies, and older on the average than the patients with any of the other forms of vulvar carcinoma. Presenting complaints are usually soreness, some itching, a burning sensation, and extreme tenderness. The areas of epidermal involvement on the labium majus are sharply defined, the tissues thickened, edematous, red, moist, and eczematoid.

On histologic examination, the epidermal involvement has frequently been described as presenting a "torn lace" appearance with Paget cells scattered singly and in clusters throughout an otherwise normal-appearing layer (Fig. 3). These Paget cells have vesicular nuclei and pale or vacuolated cytoplasm, and give a positive reaction for mucin. Similar cells are found in the skin appendages, especially the apocrine sweat glands. In assessing biopsies it is important not to confuse the involvement of skin ap-

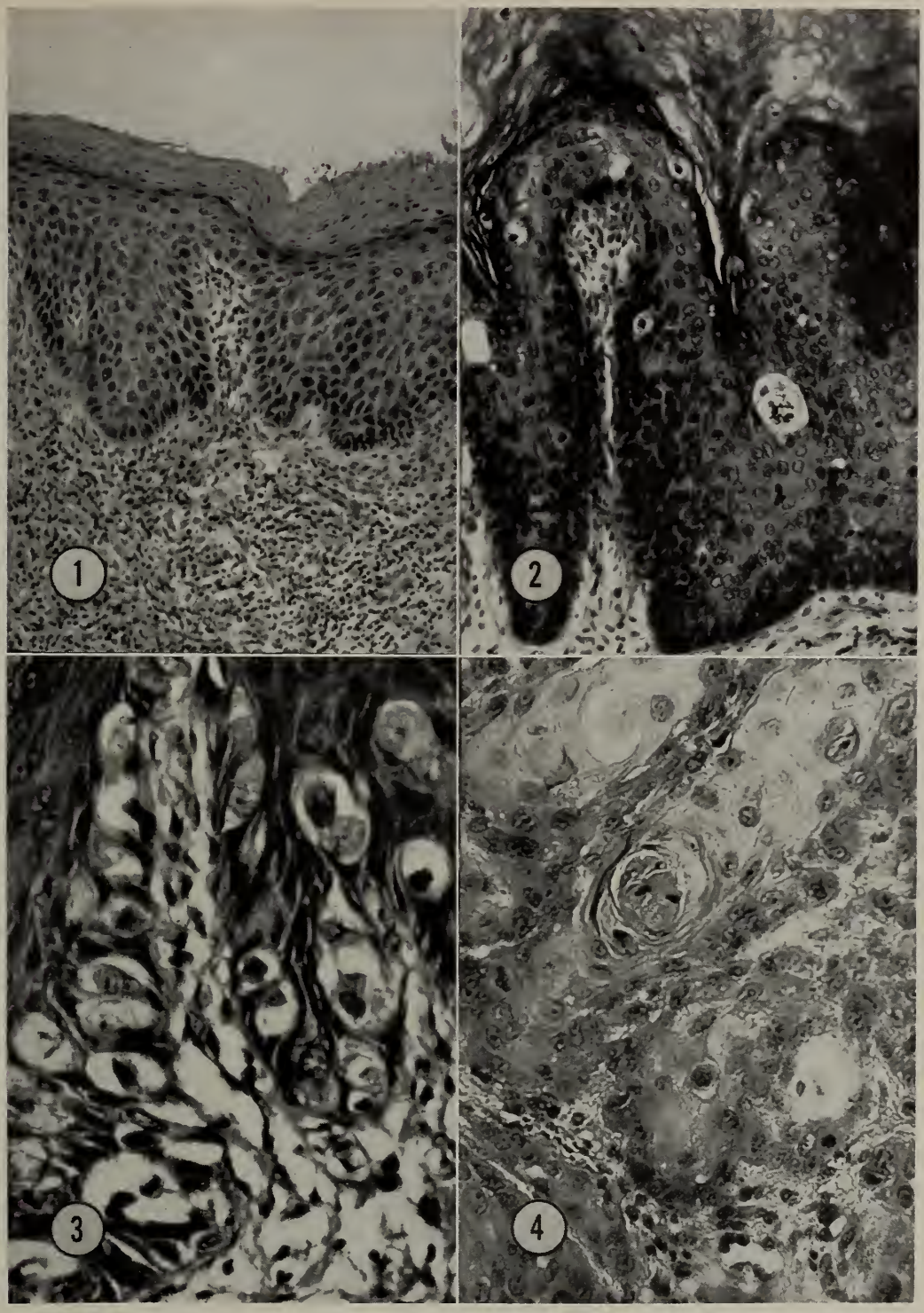


Fig. 1. Intra-epithelial squamous cell carcinoma, simplex type. There is thickening of the epidermis with acanthosis and parakeratosis. The squamous cells are hyperplastic with hyperchromatic nuclei and scattered division figures. The bizarre atypicalities of Bowen's disease are absent.

Fig. 2. Intra-epithelial squamous cell carcinoma, Bowen's type. There is a marked atypical hyperplasia of epidermis with marked hyperkeratosis, corps ronds, prominent grains, and frequent division figures. There is no infiltrative growth.

Fig. 3. Intra-epithelial carcinoma, Paget's type. The epidermis is thickened and Paget's cells are scattered throughout, primarily near the basal layer. The intervening squamous cells appear normal. There was no infiltrative carcinoma in this specimen.

Fig. 4. Infiltrative squamous cell carcinoma consisting of nests of atypical but well-differentiated squamous cells forming whorls and keratin pearls.

pendages with infiltrative growth. Histochemical procedures may be required to differentiate the lesion from an achromatic or relatively achromatic melanoblastoma.

Infiltrative Squamous Cell Carcinoma

Epidermoid Type.—This lesion comprises the bulk of carcinomas of vulva and is the type generally referred to when a writer simply speaks of vulvar carcinoma. Its development is frequently preceded by leukoplakic vulvitis or chronic granulomatous disease. Because of its epidermoid features, it is often viewed simply as carcinoma of skin, and its extremely lethal nature is ignored.

These patients are typically post-menopausal with an average age in the early sixties.[8] While some centers report a high incidence of previous granulomatous disease of the vulva,[9] only five patients in our series gave any such history. The commonest symptom is vulvar pruritus which is frequently of several years' duration and often associated with benign vulvar irritation which preceded the carcinoma. Perhaps, because of the chronic nature of the complaint, the patient is inclined to be slow in seeking medical attention. In this series, thirty patients were aware of a vulvar tumor, and ten of an ulcerated bleeding lesion, for an average of nine months before they sought medical advice.

This form of carcinoma rarely offers any difficulty in histologic diagnosis. It is usually a well-differentiated lesion with a good deal of keratin formation. The cells closely resemble squamous cells, form keratin nests and whorls, and sometimes prominent intercellular bridges (Fig. 4). Although the nuclear abnormalities of malignancy including division figures are present, they are not as striking as, for example, most forms of carcinoma of uterine cervix. In a review of 133 cases, which are included in this series,[8] areas of *in situ* carcinoma were observed in association with 18 per cent of the infiltrative lesions. Twenty-six per cent of the lesions in the vulvectomy specimens were multicentric in nature.[8] Changes of either leukoplakic vulvitis or kraurosis vulvae were present in 64 per cent of the lesions.

Bowenoid Type.—Nine of twenty cases of Bowen's disease of this series had associated areas of infiltrative growth. These areas possessed histologic features which differed from the usual form of epidermoid carcinoma; keratin formation was less and division figures, especially bizarre forms, were more frequent. There were also vacuolated cells resembling corps

TABLE II. MALIGNANT EPITHELIAL TUMORS (CARCINOMAS) OF VULVA

Type of Tumor	Number of Patients	Total
I. Intra-epithelial squamous cell (*in situ*) carcinoma		19
(a) Simplex type	8	
(b) Bowen's type	11	
(c) Paget's type	0	
II. Infiltrative squamous cell carcinoma		160
(a) Epidermoid type	151	
(b) Bowenoid type	9	
III. Primary adenocarcinoma		3
(a) Vestibular or vulvovaginal glands	2	
(b) Ectopic breast tissue	1	
(c) Apocrine sweat glands (hidradenoid)	0	
(d) Mesonephric duct	0	
IV. Basal cell carcinoma of skin	4	4
V. Pseudoadenomatous (adenocystic) basal cell carcinoma of vestibular glands	0	0
VI. Infiltrative Paget's disease	0	0
Total	186	186

ronds, and multinucleated tumor giant cells similar to those seen in the intra-epithelial phase of the disease. Although the lesions appeared less well differentiated than the orthodox form of squamous cell carcinoma, the progression seemed slower and the prognosis better. These interpretations, however, must be further evaluated by the assessment of larger numbers of this form of carcinoma. Certainly the histologic as well as the clinical features justify its separation from the usual form of squamous cell carcinoma in this area.

Primary Adenocarcinoma

Primary adenocarcinoma of the vulva is a rare disease and most examples that have been reported have arisen from the vestibular glands, especially the greater vestibular (Bartholin's) glands. Other sites of origin include sweat glands of vulva, mesonephric remnants, and ectopic breast tissue.

The majority of carcinomas of Bartholin's gland are gland cell carcinomas (adenocarcinomas) (Fig. 5), the others being squamous cell carcinoma.[10,11] The patterns of growth vary considerably, and this accounts for the wide variety of descriptive names applied to the different lesions. The patterns of growth which are most frequently encountered are simplex, medullary, muciferous, and acanthoid (acanthoadenocarcinoma). The majority of tumors appear between the ages of forty and sixty years and present as a nodule in the region of Bartholin's gland covered by intact mucosa. Some neoplasms may be soft or cystic and mis-diagnosed as a cyst or chronic hypertrophic inflammation. The five-year survival rate for the cases reported in the literature is approximately 10 per cent. Two of the adenocarcinomas of vulva listed in Table II were considered to have arisen in Bartholin's gland.

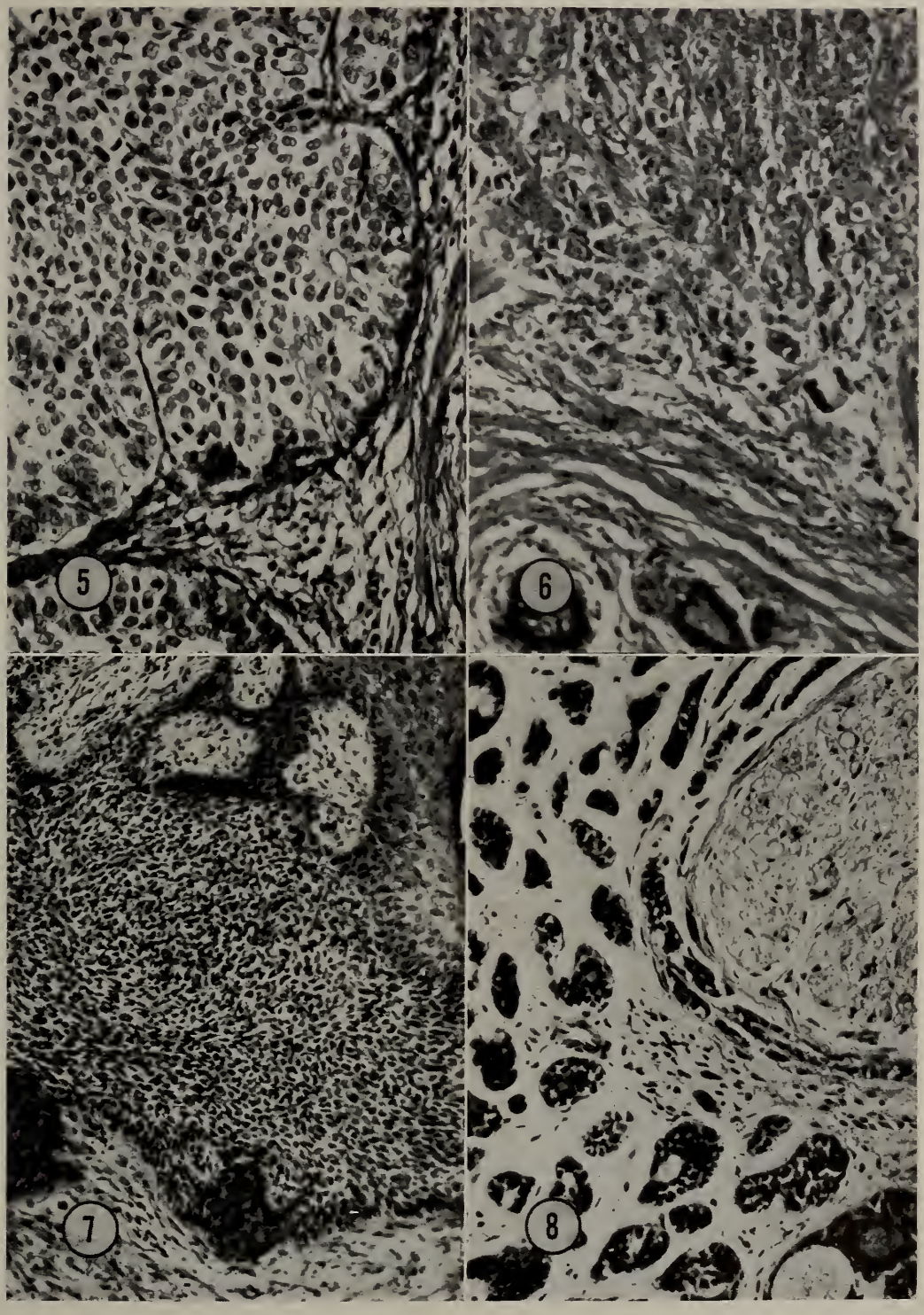


Fig. 5. Medullary gland cell carcinoma (adenocarcinoma) of Bartholin's gland. There are lobular masses of carcinomatous cells which are attempting to form small acinar spaces.

Fig. 6. Scirrhous carcinoma of ectopic breast tissue. The neoplastic cells arranged primarily in cords are adjacent to a portion of a lobule of mammary tissue.

Fig. 7. Basal cell carcinoma of skin of vulva. Masses of small uniform basal cells extend into dermis from the basal layer of epidermis and hair follicles.

Fig. 8. Pseudoadenomatous basal cell carcinoma of vestibular glands. The small neoplastic basal-like cells are in nests and clumps throughout a loose pale stroma. Clumps of neoplastic cells are within perineural lymphatic channels.

The one example of primary adenocarcinoma which arose in ectopic mammary gland tissue has been reported by Hendrix and Behrman[12] (Fig. 6). Greene[13] also reported adenocarcinoma of supernumerary breast in labia majora. Origin from ectopic breast tissue must be considered for otherwise obscure primary gland cell carcinomas of vulva.

Hidradenomas of vulva, sweat gland adenomas, usually of apocrine origin, were at one time interpreted as well-differentiated adenocarcinomas.[14] Although carcinoma may arise in sweat glands, either *de novo* or as a carcinomatous change in a pre-existing hidradenoma, such an occurrence is extremely rare. It is also possible that gland cell carcinomas of vulva may develop from mesonephric remnants, endometriosis, and Skene's ducts, but we have not recognized any such lesions in this series.

Basal Cell Carcinoma of Skin

This lesion is histologically similar to basal cell carcinomas of cutaneous origin that are found on other surface areas of the body. They arise from either the surface epithelium or the epithelium of skin appendages, or both. They are frequently multicentric in nature. This form of basal cell carcinoma must not be confused with basal cell carcinoma of glandular origin. Approximately 100 cases have been reported in the literature.[15-17]

The lesions are found on the labium majus, almost exclusively in Caucasians over sixty years of age. They appear as slowly-growing, painless nodules, the only symptom frequently being slight itching or serosanguineous discharge when the lesion has ulcerated. Various growth types are seen, including the classical rodent ulcer which is an ulcerated nodule with indurated, pearly borders. In other instances the tumor may appear to lie within the dermis presenting a firm nodule covered by a thin but intact epidermis. A third growth type appears as superficial erythematous scaly patches, and is frequently multicentric in nature. Any of the lesions may possess considerable melanin pigment.

Histologically, various patterns of growth are encountered. The lesions are seen to arise from epidermis or skin appendages, or both, and to spread into the adjacent dermis (Fig. 7). The predominant cells are small with minimal cytoplasm and hyperchromatic nuclei. They may produce small amounts of keratin and in the vulva they frequently contain granules of melanin. There is no relationship of this lesion to leukoplakic vulvitis or to the various types of vulvar granuloma.

Extension of the neoplasm is by direct infiltration of the dermis and subcutaneum, and for practical purposes, metastases do not occur. Local recurrences, however, may take place if excision is not adequate. The pigmented basal cell carcinoma must be differentiated clinically and histologically from melanoblastoma.

Pseudoadenomatous Basal Cell Carcinoma of Vestibular Glands

This is a distinctive histological lesion which is identical to lesions of major and minor salivary glands, mouth, tongue, pharynx, nasopharynx, paranasal sinuses, lacrimal glands, trachea, bronchus, esophagus, and mammary gland. It has also been designated cylindroma[18] and adenocystic basal cell carcinoma.[19] We prefer the terms pseudoadenomatous or adenocystic basal cell carcinoma.[20,21] The lesion should not be confused with basal cell carcinoma of the skin or with a possible malignant change in a pre-existing hidradenoma. The origin is considered to be from ducts of either the lesser or the greater vestibular glands. Although no cases are included in this series (Table II), we have encountered two such lesions, both of which were thought to arise from lesser vestibular glands.

Histologically, the tumors consist of small basal cells with little cytoplasm and relatively large hyperchromatic nuclei. Division figures are usually infrequent. The cells form pseudoacini, anastomosing cords, and medullary sheets, often with an intervening basophilic stroma (Fig. 8). In approximately one-quarter of the cases there is a dense hyaline stroma about the cords of cells and this accounts for the inappropriate name *cylindroma*. Although the lesions grow slowly, they infiltrate locally, have a marked tendency to spread by perineural lymhatic channels, and metastasize to the lung. Recurrences are frequent and often take place many years after the original surgical procedure. Both the recurrences and the metastases grow slowly and the patients may live for long periods comparatively free of symptoms. The natural history of the neoplasm and its distinctive histologic appearance require that it be separated from other forms of vulvar carcinoma.

Infiltrative Paget's Disease

Extramammary Paget's disease of the vulva is a distinct entity, as previously mentioned. Whether all forms have an *in situ* phase as such can be debated, but certainly some forms of the disease when initially diagnosed appear to be intra-epithelial

and other forms when first seen show fairly extensive infiltration of the dermis. The infiltrative form of Paget's disease runs the expected course of carcinoma with metastases to regional lymph nodes and sometimes distant metastases to various organs throughout the body.[3,22-24] We have encountered no examples of this type of carcinoma during the period selected for review.

Treatment

In considering treatment, the important decision depends upon the presence or absence of invasive growth in the initial biopsy. Little distinction among morphologic groups need be made beyond this point. Thus, for example, the various types of adenocarcinoma are considered invasive and treated with radical excision. Only for the infrequent basal cell carcinomas do we make any real change in therapy.

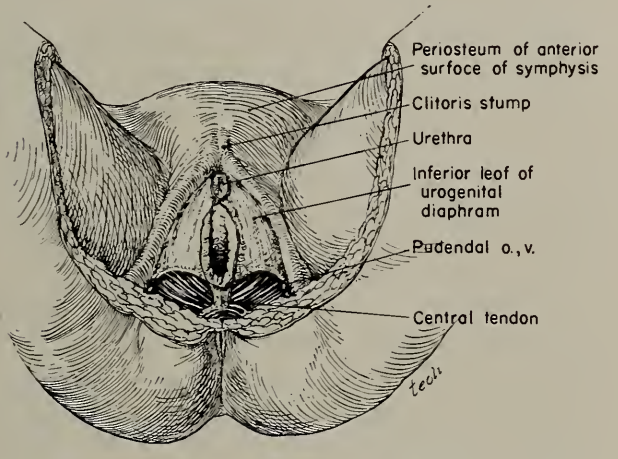


Fig. 9. Radical and wide vulvar excision down to inferior leaf of urogenital diaphragm.

Invasive Carcinoma.—Surgery for invasive carcinoma has been widely discussed, and the details of the method vary among authors.[25-28] Be this as it may, in the surgical objectives accomplished, they are all in essential agreement:

1. Wide vulvar excision to the lateral margins of the perineal area and completely down to the inferior fascia of the urogenital diaphragm (Fig. 9).
2. Bilateral dissection and removal of superficial inguinal lymph nodes and tissues (Fig. 10).
3. Bilateral removal of the deep inguinal and femoral nodes, round ligament, and associated tissue from the inguinal canal.
4. Bilateral dissection and removal (extraperitoneally) of the external iliac nodes and the nodes in the obturator area (Fig. 11).

The massive wound which results may almost always be closed in part, in the inguinal areas particularly. The surgeon should, however, remember the considerable healing power inherent in the peri-

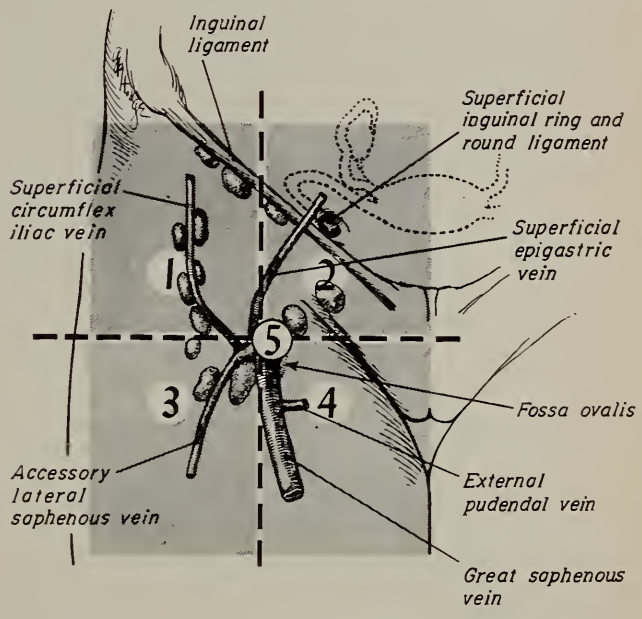


Fig. 10. The main points of superficial inguinal dissection: (5) Fossa ovalis and connecting point with femoral vein of (4) greater saphenous and external pudendal, (3) lateral saphenous, (1) superficial iliac circumflex, and (2) superficial epigastric veins. Note also the round ligament which inserts into labium majus.

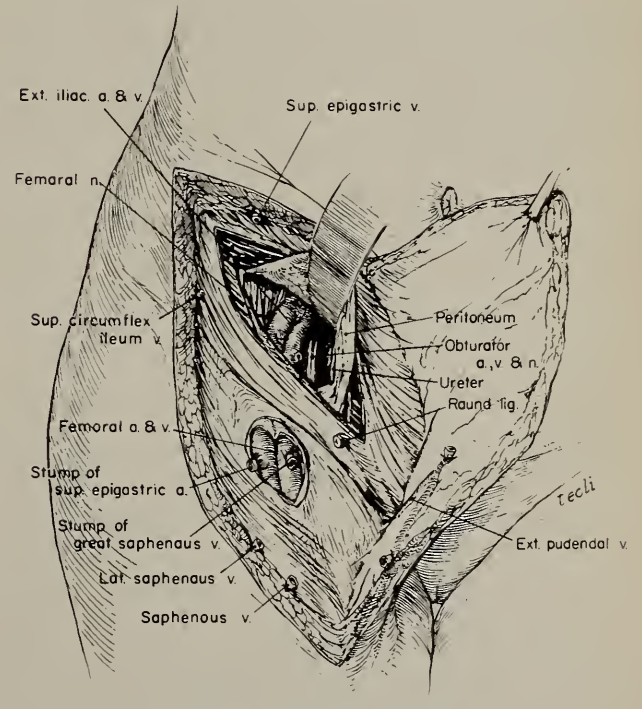


Fig. 11. Extraperitoneal approach to external iliac and obturator lymph nodes after opening and evacuating the inguinal canal.

neal area and leave the greater part of the repair to nature. Efforts to pull the lateral and anterior margins of the vaginal mucosa to the margins of peripheral skin are particularly unwise for this almost always pulls the urethra downward and thus obliterates the posterior urethro-vesical angle. The incontinence which such distortion can produce will serve to make care of the granulating, incompletely healed wound still more difficult.

The presence of this wide, partially or largely open, granulating wound presents several special problems. Significant loss of tissue fluids from such a surface makes periodic checks of serum proteins and electrolytes a necessary precaution. The patient would profit from the protective use of antibiotic therapy and should be continued on indwelling catheter drainage for eight to ten days. The early institution of saline irrigations and saline dressings maintains cleanliness. This may later be supplemented by the use of sitz baths and perineal bakes. It is possible, though not often required, to accelerate the ultimate healing further by the use of split-thickness skin grafts. These can only be undertaken when there is already established a clean, regular, granulating base to the wound.

The ultimate healing result is usually far less disfiguring than the initial wound would lead one to expect. What scarring and distortion does take place is reduced in younger women whose more vascular and resilient tissues heal better. We have in our own records authenticated cases of at least two vaginal deliveries of infants after radical vulvectomy, and there are doubtless others.

That such wide surgical excision is indicated for any invasive lesion is supported by all that is known of the behavior of vulvar cancer. Once the disease has entered lympathic channels its potential for spread into contralateral tissues and lymph nodes is virtually as great as for spread on the side of the lesion. When we compare absolute survival rates for the invasive carcinomas in the group under study, we find the patients who have had radical vulvectomy and inguinal node dissection (approximately one-half the total series) had a 63 per cent five-year survival rate, while those who had some lesser degree of surgical excision had a rate of only 31 per cent. It must be pointed out that the group with lesser surgery included some advanced cases in which only palliative vulvectomy could be done, but it also included a good many cases in which the lesion was so early, or at least so small, that the physician felt a lesser procedure than radical vulvectomy would certainly suffice to remove the tumor entirely.

A system of clinicopathologic staging of carcinoma of vulva treated by complete vulvectomy and bilateral lymph node dissection has been devised which appears to allow an accurate evaluation of treatment.[8] This system is as follows:

Stage I: Unicentric infiltrative squamous cell carcinoma restricted to dermis.

Stage II: Unicentric carcinoma restricted to vulva but infiltrating subcutaneum, or multicentric carcinoma restricted to vulva irrespective of depth of infiltration.

Stage III: Infiltrative squamous cell carcinoma with metastases to regional lymph nodes.

Stage IV: Advanced infiltrative squamous cell carcinoma with regional infiltration of vagina, rectum, or urinary bladder; or distal metastases.

Using this classification, the crude five-year survival rate for Stage I carcinoma was 90 per cent, for Stage II, 69 per cent, and for Stage III, 25 per cent. If the stage of the disease is combined with the histologic grade of the disease the prognostic value is greatly improved; five-year survival rate for Stage I, Grade I carcinoma was 100 per cent.[8]

Intra-epithelial Carcinoma.—In instances when the initial biopsy reveals only intra-epithelial carcinoma, what should the course of action be? The answer in this group is, perhaps, a bit less clear-cut, but the authors have come to hold certain definite beliefs:

1. Wide total vulvar excision, essentially radical vulvectomy, is the procedure of choice.

2. The specimen so obtained is serially blocked and a large number of sections are examined.

3. If any area of invasion is identified, then a bilateral inguinal lymph node dissection is done as a "second stage."

Such an aggressive procedure is dictated by the natural history of *in situ* disease of vulva, as we have come to understand it. It is entirely possible that isolated areas of invasion may exist in conjunction with extensive *in situ* carcinoma in the large majority of cases. Our own examinations have convinced us that this is often so. We are also convinced that this is never a decision which can be made on gross clinical inspection alone. It is even more certain that *in situ* carcinoma is typically multicentric, rendering any single local excision futile in

either eradicating local *in situ* disease or in eliminating the possibility of invasive growth in some other area.

Significant survival figures to support the wisdom of the more radical approach cannot be derived from so small a series as this, but it is interesting to note that recurrence of local malignancy was almost twice as common in the limited excision group as in the group treated initially with radical excision.

Basal Cell Carcinoma of Skin Vulva.—This very small group remains the one refuge of the wide local excision concept of treatment for carcinoma. In these patients alone can one justify the partial or simple vulvectomy with any hope of eradicating the disease. Results of such limited treatment are generally good but the patient should be kept under clinical observation.

This concept of local excision *does not*, however, apply to the pseudoadenomatous type of basal cell carcinoma. This lesion has all the ability to metastasize that the invasive squamous cell cancer possesses. Therefore radical vulvectomy and bilateral inguinal lymph node dissection are indicated.

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The Undevout Astronomer Is Mad

Who sees the varying orbs in order rise; progress unjarring, wax and wane, and vanish; as if self-poised, self-guided, self-existent; and is not thereby led to view a God, to cause to guide, and balance, orb and orbit, through the immense of Heaven's extended space:—Is but a dunce in Nature's highest school; a blinded atheist, maniac, or fool.—ANONYMOUS, 1800.

Pseudosarcomatous Fibroblastic Proliferations

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FIBROBLASTIC proliferations and fibroblastic tumors capable of local recurrences or of distant metastases pose serious problems of classification and frequently behave in unpredictable fashion. Well-known histologic criteria for most benign and malignant tumors of epithelial origin seem to be of little value in diagnosis and grading of fibroblastic lesions.

Histologically similar, well-differentiated fibroblastic lesions may display entirely different clinical behaviors, producing in one instance numerous although delayed recurrences and eventual distant metastases, remaining localized in another and failing to recur after excision. On the other hand, some fibroblastic proliferations which exhibit histologically an alarming degree of cellular activity, with atypical nuclei and even bizarre mitotic figures, are amendable to simple excision and rarely produce distant metastases.

This latter group of lesions is the subject of this discussion. Malignant tumors of fibroblasts, known as "fibrosarcoma," were thoroughly reviewed by Stout in 1948,[1] who noted that histologic criteria alone are not sufficient for accurate diagnosis and that prognosis depends on localization of the tumor and probably upon the patient's personal predisposition. Fibroblastic tumors arising in the skin have more favorable prognoses and rarely produce distant metastases. It is even difficult to tell whether these lesions represent true neoplasms, or fibroblastic proliferations after known or unknown trauma. Histologic criteria for fibrosarcoma describe a lesion made up of spindle-shaped fibroblastic cells containing elongated nuclei and showing variable content of chromatin material. In those which are well differentiated, collagen formation is prominent and individual fibroblasts are fairly well separated from each other. In more malignant forms, cells are set close together and reticulum, as well as collagen fibers, are scanty. Differentiation also depends on amount and distribution of chromatin material, as well as on demonstration of increasing numbers of abnormal mitotic figures. According to Stout, fibrosarcoma may display either a pattern of interlacing fascicles or a formation of spiral-like whorls with almost 90 degree angles forming at the line where two nodules meet. With only these criteria as we shall see, diagnosis of fibrosarcoma, a tumor capable of distant metastasis but usually characterized by frequent local recurrences, cannot always be made only on histologic basis.

Fibroblastic lesions of benign nature, like fibrosarcoma, are of unkown etiology. Some occur in patients who give history of trauma which might be the result of stretching of abdominal muscles during pregnancy, and originate from scar tissue as in desmoid; or from chemical or thermal cutaneous burns which may stimulate the development of invasive and occasionally metastasizing true fibrosarcomas. Local ionizing radiation in excessive doses, which usually produces chronic radiodermatitis and malignant epithelial tumors, may also lead to formation of fibroblastic hyperplasia, irradiation fibrosis, and local recurrence. While all these traumas may predispose, in the majority of cases etiology is unknown. We wish to describe benign fibroblastic tumors in which histologic evidence of sarcoma exists.

Desmoid tumors usually appear in abdominal muscles and fascia of women following pregnancy. They show infiltrative growth into striated muscle, and are formed by well differentiated fibroblasts with abundant collagen fibers. Desmoid tumors may grow to be 6 or 7 cm. in diameter, and even recur locally, but apparently never produce distant metastases (Fig. 1). Occasionally, similar tumors are found in sites other than the abdominal muscles, as described by Mason in 1930.[2]

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Fig. 1. Desmoid tumor of the abdominal wall. The tumor is composed of proliferating fibroblasts and is poorly encapsulated. Note extension of fibroblasts into the striated muscle. Gross and H&E ×70.

Fig. 2. Plantar fibromatosis in an adult. Note nodules of proliferating fibroblasts. H&E ×17.

Fig. 3. Nodular fasciitis. The actively proliferating fibroblasts are associated with an inflammatory reaction. H&E ×64.

Fibroblastic proliferation in Dupuytren's contracture of palmar and plantar fascia frequently forms markedly cellular nodular lesions. We have observed numerous patients with this condition (Fig. 2). Dupuytren's contracture is closely related in appearance to desmoid tumors; and when accompanied by typical palmar or plantar contraction is easily recognized. Occasionally, it may be mistaken for fibrosarcoma, especially when it occurs in the foot and when there are frequent recurrences. There is often history of trauma and familial history for development of palmar fibromatosis. A particularly difficult problem is presented in diagnosis of juvenile fibromatosis. These tumors appear in children aged between one month to fifteen years and the more frequently involved parts are neck, hands and feet, and shoulders. The growth is nodular, non-encapsulated and infiltrative into fascia and striated muscle. Histologically, it may vary from scar-like tissue in some patients to more cellular and atypical fibroblastic growth in others. Stout[3] in 1954 cited his personal experience with forty-four cases of juvenile fibromatosis and concluded that except for a few lesions (keloidal fibromatosis, plantar fibromatosis and juvenile aponeurotic fibromas) no definite prediction of their behavior could be made. The lesions may recur and show, on few occasions, relentless localized infiltrative growth; but in no instance have distant metastases been found.

Nodular fasciitis also deserves brief mention. It may occur in young or middle-aged individuals, in subcutaneous tissues of the extremities, or deep within muscle. The lesion is not encapsulated and is poorly circumscribed. Histologically, it shows a typical feathery pattern with swollen fibroblasts, edema, and scattered lymphocytes and macrophages, an appearance which differentiates this lesion from other types of fibromatoses (Fig. 3). Local excision is the usual treatment; recurrences are rare.

Another lesion which may follow trauma is myositis ossificans. In this peculiar condition fibrosis occurs accompanied by infiltration of striated muscle by immature young fibroblasts with foci of cartilage and bone formation. We have seen such a lesion in a fifty-five-year-old man, who, with hematoma in the leg, developed rapidly increasing swelling and induration of the muscles of the thigh four weeks after an automobile accident. The mass measured 10 x 5 cm., and was hard and fixed but not tender. It was attached to underlying bone. Biopsy showed active fibroblastic proliferation, islands of cartilage, and immature bone formation (Fig. 4). Differential

diagnosis requires consideration of periosteal osteogenic sarcoma. This lesion can be easily over-diagnosed if history of trauma is not considered.

Dermatofibrosarcoma protuberans (Hoffmann) and progressive recurrent dermatofibroma (Darier) represent similar fibroblastic proliferations occurring in the skin. In each instance there are well differentiated interlacing bundles of fibroblasts, usually with abundant formation of collagen fibers. Mitotic figures are not present and differentiation of these two cutaneous fibroblastic proliferations lies in their gross appearance: a single nodule occurs in dermatofibroma of Darier, while numerous nodules form in dermatofibrosarcoma protuberans. There is induration and reddish discoloration of the skin; metastases are unknown, but the recurrence rate is quite high.

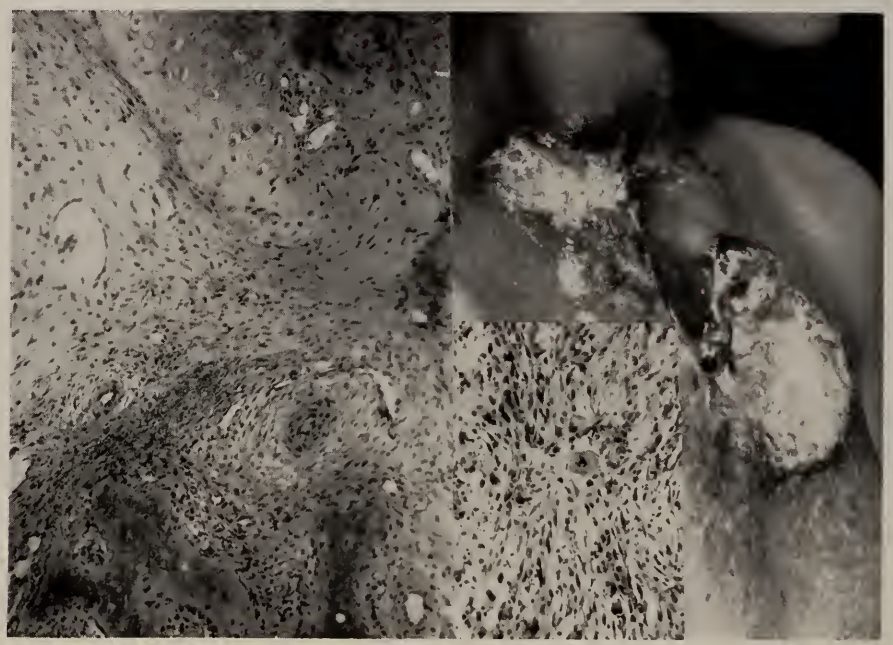


Fig. 4. *(left)* Myositis ossificans. Note the proliferating fibrous tissue, bone and cartilage. H&E ×64.

Fig. 5. *(right)* Post-irradiation pseudosarcoma of skin over sternum. Note bulky ulcerated tumor grossly and actively proliferating fibroblasts with bizzare mitotic figure. H&E ×64.

Ionizing radiation can produce damage to collagen tissue of the skin which in most patients will subside following the acute phase with disappearance of edema and of young and abnormal fibroblastic cells. Residual fibrosis may be noted on examination of such previously irradiated skin, but in most patients this reaction is negligible. Progressive irradiation fibromatosis and pseudosarcomatous fibroblastic proliferation may develop occasionally following treatment for various benign and malignant skin lesions and for deep seated tumors. The first case of fibrosarcoma of the skin following radiation was reported by Perthes in 1904.[4] Numerous reports of this development have appeared in the literature. Deuticke in 1939[5] made an extensive review on sarcomas arising in the skin of patients treated by ionizing irradiation for lupus vulgaris or for tuberculosis of joints. It was already noted more than twenty years ago that the rate of distant metastases from these lesions was low except from those in the vicinity of bone; in patients with these lesions, fibroblastic tumors forming cartilage and osteoid material produced distant metastases more frequently. It is, however, probable that these lesions arise from irradiated bone. Pettit[6] in 1954 noted progressive irradiation fibromatosis and fibrosarcomas in patients treated by irradiation.

We have studied five patients previously treated by irradiation who developed pseudosarcomatous fibroblastic lesions in the skin, separately or associated with malignant epithelial tumors. Their ages ranged from twenty-one to forty-three years; the latent period between irradiation and first occurrence of the lesion ranged from one and a half to eighteen years. Some fibroblastic lesions recurred locally, and in one patient unrestricted local growth was the immediate cause of death (Fig. 5).

One of these patients died from a separate squam-

ous cell carcinoma which developed in an area of chronic radiodermatitis; and another succumbed to malignant lymphoma. In none did pseudosarcomatous tumor produce distant metastases. Histologically, such lesions are composed of active young fibroblastic cells showing variable amounts of collagen formation, marked pleomorphism and atypical nuclei, frequent giant mononuclear forms, and abundant abnormal mitotic figures. In one instance, the tumor also formed immature cartilage and bone.

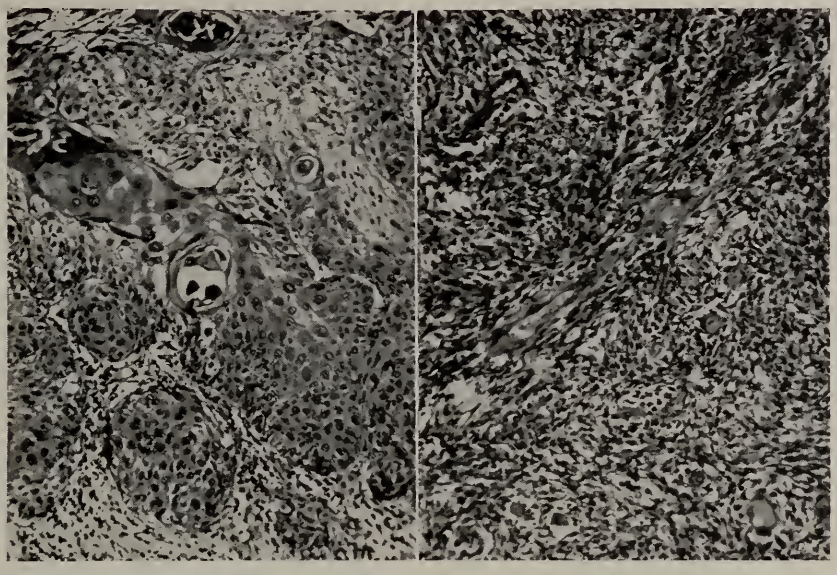


Fig. 6. Pseudosarcoma of larynx associated with squamous carcinoma. The spindle cell fibroblastic element forms the bulk of the tumor. H&E ×64.

Lane[7] and Stout[8] in 1957 described peculiar polypoid and pedunculated tumors occurring in esophagus, larynx, and oral cavity. These had bulky, edematous appearances and ulcerated surfaces. These lesions were composed largely of young immature fibroblasts forming whorls and interlacing bundles and showed inflammatory infiltration and edema between individual cells and bundles. These tumors were always associated with squamous cell carcinoma; and the carcinomatous component was sometimes either inconspicuous or superficial. In patients in whom metastases to regional lymph nodes occurred, only the carcinomatous component could be found in the secondary deposit. Carcinomas were of squamous cell type and sometimes hard to find on surfaces of these large partially ulcerated and inflamed tumor masses, unless the condition was suspected and careful search was made for squamous cell carcinoma. A striking finding associated with squamous cell carcinoma was the alarming degree of cellularity and bizarre mitotic figures of the fibroblastic component, indicating histological malignancy. However, the pseudosarcomatous element has never produced distant metastases and thus resembles pseudosarcomas of the skin following irradiation.

We have studied pseudosarcoma of the larynx associated with squamous cell carcinoma of the vocal cord in a forty-year-old man with intermittent hoarseness of five and one-half years' duration. He had a smooth, greyish, pedunculated mass, approximately 2.5 cm. in diameter, arising from the anterior surface of the left vocal cord. The bulk of the tumor was produced by bizarre fibroblastic growth and only occasionally on the surface were there islands of intra-epithelial and invasive cell carcinoma (Fig. 6). The other lesion occurred on the gum of the mandible of a seventy-six-year-old woman. She gave a history of a sore on the gum for two months; at examination, a granular lesion was seen between the remaining molar teeth. Histologically, this appeared to be a sarcomatous fibroblastic growth composed of spindle-shaped cells forming abundant collagen material and arranged in interlacing slender strands and bundles. On the surface of the lesion there was well differentiated squamous cell carcinoma showing foci of infiltration into the underlying mass of atypical fibroblasts. Large hyperchromatic cells, pyknotic nuclei, and abnormal mitotic figures were present in both of these cases. These patients had been treated by local excision followed by x-ray therapy. Etiology of this condition is unknown but one explanation is that this represents a peculiar, abnormal fibroblastic

proliferation, initiated by overlying intra-epithelial or invasive squamous cell carcinoma. An inflammatory component was present in these lesions in our two patients, a finding also noted previously by Lane.

Treatment is primarily surgical; wide excision in normal tissue should be carried out as for squamous cell carcinomas. In patients so treated the rate of local recurrence was low.

Discussion and Conclusions

Following almost any injury to collagenous connective tissue, there may be active fibroblastic proliferation in the skin and callus formed at the site of fracture. In this normal reaction to injury, fibroblastic activity subsides and collagen bundles appear and become hyalinized in varying degrees. Following natural repair of trauma, scars form. In a few patients, however, fibroblastic activity does not stop at this point. Instead, there is continuous proliferation, extension, and infiltration into the adjacent subcutaneous layer, striated muscles, fascia, or submucosa (in patients with oral or laryngeal lesions). Following original excision of the nodule in the skin or subcutaneous tissues the lesion may recur locally, retaining its original histologic pattern, or increasing the degree of activity and cellular pleomorphism. This is apparently the point where a line should be drawn between benign and malignant fibroblastic lesions, but it is frequently impossible to determine this line by histologic criteria alone. The benign nature of fibroblastic reaction is found in most instances but occasionally unrestricted and infiltrative growth following the same basic trauma can occur. As stated above, trauma to the skin is usually followed by scar formation and complete healing; but sometimes fibroblastic lesions, even frank fibrosarcomas with distant metastases, may develop in cutaneous scars. Chronic irritation of the wound, infection, and underlying chronic osteomyelitis have been complicating and inciting factors.

Stout[1] thought that trauma was not a significant factor for development of fibroblastic proliferations. However, his findings in thirty-six patients in whom fibrosarcomas developed in scars, and who had plantar fibromatosis usually following traumatic injury, were against this view. Pseudosarcomas of the skin following irradiation appear to have a definite relation with fibroblastic growths and previous injury from ionizing irradiation; and pseudosarcomas occurring in the oral cavity, in the larynx and in the esophagus, also apparently represent peculiar response to overlying squamous cell carcinomas.

We still cannot explain why a few patients react with bizarre pseudosarcomatous fibroplastic proliferation to the same degree and kind of trauma which generally produce only the fibroblastic activity necessary for repair. Apparently personal susceptibility and predisposition to excessive, sometimes unrestricted cellular proliferation are important factors.

Summary

An attempt is made to draw more definitely the line between benign and malignant fibroblastic activity following injury. Histological criteria are pointed out and examples of bizarre fibroplastic lesions, especially pseudosarcomas, are discussed in the light of the authors' experience. While no definite conclusion can be drawn, it appears that personal susceptibility and predisposition are at least as important as nature and location of apparently precipitating injury.

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Consider Progressive Care in Maryland

A four-year pilot program to extend the principles of "progressive patient care" to aged or chronically ill patients has been proposed by the Maryland Department of Health and the State Commission on Aging. The program, under consideration by the Governor, would call for establishing "coordinated medical centers" throughout the state, under central supervision of a medical director.

Financed by state funds, the centers would consist of an acute disease hospital for intensive therapy, a chronic disease institution or unit for patients requiring long-term treatment, and a nursing home providing comprehensive rehabilitation services for a period as long as six months.

Wilms Tumor

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NEOPLASMS arising from the genitourinary tract or from its anlage comprise a large portion of malignancies in the pediatric age group. Wilms tumor alone accounts for 20 per cent of all solid tumors in childhood.[1] Dargeon states that in a representative year many more pediatric deaths were attributable to urogenital tumors than to tuberculosis, at least in patients under five years of age.[2] The frequent occurrence of these tumors and multiple facets they present in diagnosis and treatment prompted this review of Wilms tumors.

Since Gairdner, in 1828, recorded the first case of renal sarcoma in infancy, more than 2,000 have appeared in the world literature. In 1878, Kocher performed the first transperitoneal nephrectomy for this disease, and in 1899, Wilms published his now famous monograph on mixed renal tumors.[3] Since that time they have borne his name. Multiple theories have been advanced to explain the genesis of this tumor. Ribbert attributed the tumor to abberant totipotential sex cells at the very earliest stage of development. Wilms, on the other hand, believed the tumors arose at a later date prior to the development of the mid-dorsal mesodermal derivatives. Birch-Hirschfield after a careful histologic study concluded that the tumor arose from Wolffian body inclusions in the growth of the renal bud. Ewing[4] and others point out that there is such a great multiplicity of tissues in the tumor that it probably arises from the fetal kidney *per se*. Dean and Pack[5] hold the impression that because of the wide variety of histologic patterns that may be seen in this tumor, it probably develops at different times in embryonic life. Thus, if the tumor exhibits fairly well-defined tubular rosettes with some primitive glomerular structures, it is probably derived late in fetal life. Although Wilms originally described a truly mixed type of tumor with recognizable stromal and glandular elements, one often sees differentiation into other forms, some of which closely resemble rhabdomyosarcoma. Thus it becomes obvious that a strict histogenetic name is impractical in this histologically variegated tumor. We may properly call them all Wilms tumors rather than using one of the more than fifty-three names that have been applied to this lesion.

There is no apparent difference as to sex or site of involvement. The tumor has been described in the fetus and in a seventy-year-old man. More than 90 per cent occur in children less than ten years of age, and 60 per cent occur in children less than five years of age. Approximately 10 per cent are bilateral, and Campbell[6] states that in 6.5 per cent, the tumor is present at birth; and it has been recorded as large enough to cause dystocia.[7]

Material

Forty-one cases of Wilms tumors have been studied. There were twenty-two females and nineteen males. Fourteen of the patients were Negro and seventeen were white children. In fifteen, the tumor was located on the right side and in twenty-five, it was on the left. There was one case of bilateral involvement.

The symptoms of Wilms tumor are well known. To the triad of flank mass, hematuria, and pain can be added fever, cachexia and other generalized signs of spread of the neoplasm. In our series of forty-one cases, the initial complaint or symptom is noted in Table I.

TABLE I. INITIAL SYMPTOM OR SIGN IN WILMS TUMOR

Mass	23
Abdominal pain	8
Fever	5
Hematuria	3
Weakness, Malaise, Pallor	2
	41

On careful physical examination, a palpable mass was present in all forty-one patients. Dean[8] found an abdominal mass in 66 per cent of his patients, and Lattimer noted it to be the initial complaint in 12 per cent of his large series.[9] Mass or enlarged abdomen is certainly the most common complaint and one which the mother often brings to the attention of the pediatrician. It is interesting that ab-

dominal pain was the next most common presenting complaint (20 per cent) in our series and was present primarily in the three to five-year age group. Fever is a common symptom of Wilms tumor. It occurred as the initial complaint in 14 per cent of our cases, although Lattimer cites it as present in 44 per cent of his series. In surveying the whole group from our hospitals, it was noted that twenty-seven (68 per cent) of these cases had temperature elevations at the time of admission to the ward. The fever may be due to liberation of products from varying areas of tumor necrosis that are present grossly as well as microscopically or it may represent an antigen-antibody response of the host to circulating tumor cells. As is the case with hypernephroid tumors in the adult, fever usually disappears when the tumor is resected. Its reappearance may herald recurrence or metastatic disease. While hematuria was the initial complaint in 7 per cent of our cases, red blood cells were present in the urine of 20 per cent of them. Thus hematuria, whether it be gross or microscopic, is always total hematuria, that is, appearing throughout the stream. It may be the consequence of renal congestion secondary to pressure of the tumor on the renal veins, or it may represent actual invasion of the renal collecting system by the tumor and, as such, is almost always a late sign of the tumor. Constitutional symptoms including weight loss, cachexia, and pallor were noted in 5 per cent of our patients, and were generally associated with tumors of large size and with metastatic disease. Hypertension, like the fever, almost always regresses after the tumor is removed. Speculation that the tumor contains a pressor substance is justified because the hypertension may recur when even extra-abdominal metastases appear. Hypertension was present in six of the thirteen patients in whom blood pressure was recorded (an incidence of 46 per cent). Lattimer noted it in 60 per cent of his patients, and others have noted it to be a common symptom of this tumor.[9] Almost all the patients in our series received postoperative roentgen therapy, but its effect was difficult to measure objectively. It was certainly the cause of death in one patient with renal failure consequent to postradiation nephritis who, at postmortem examination, was free of recurrent tumor.

Differential diagnosis includes hydronephrosis, neuroblastoma, multicystic and polycystic disease, adrenal or pancreatic cyst, and hepatoma. Hydronephrosis can almost always be ruled out by appropriate excretory urographic study with delayed films. These two-hour and three-hour films are most helpful in delineating poorly functioning hydronephrotic kidneys. Retrograde pyelograms are rarely necessary to differentiate between Wilms tumor and hydronephrosis. Neuroblastoma usually occurs as a hard, nodular non-mobile mass in the anterior abdomen, while Wilms tumors often give a semisolid sensation to touch and is located laterally in the flank and are usually more mobile than neuroblastomas. While excretary urographic films may show deformity of the kidney's collecting system, neuroblastomas frequently appear as a suprarenal mass which depresses the kidney, while Wilms tumors often widen only part of the collecting system and almost always deform it. Wilms tumors with normal excretory urograms have been reported.[10] Retrograde pyelograms are probably contraindicated when Wilms tumor is strongly suspected on clinical grounds because of the possibility of perforation with resultant tumor dissemination.

Multicystic and polycystic disease may be strongly suspected on clinical grounds. Multicystic disease is usually unilateral, and often is found as a large flank mass in the newborn. Excretory urography rarely demonstrate function and retrograde studies are often unsatisfactory because of the frequently associated ureteral atresia. Polycystic disease most often elicits bilateral nodular flank masses in the young infant. A family history may or may not be present. These infants are often azotemic, and may show all the stigmata of renal failure. It is sometimes difficult to differentiate Wilms tumor from polycystic disease by roentgen methods, but the former is usually confined to one segment or pole of the kidney, while polycystic disease tends to involve all segments of the kidney, deforming all the calyceal groups to some degree. The diagnoses of renal and pancreatic cysts, mesenteric cysts, intestinal duplications, choledochal cysts and other less common flank or abdominal masses in children are usually made at laparotomy.[11]

A long and, at times bitter, controversy has appeared in literature concerning the role of radiation therapy in the management of Wilms tumors. One can find support for preoperative irradiation, postoperative irradiation, and no irradiation. More recent collective reviews[12] indicate that preoperative irradiation does not influence ultimate survival statistics, a few case reports nothwithstanding.[13] Our own impression is that the danger of waiting, during which time metastases may occur, far outweigh whatever advantage may accrue from preoperative irradiation. Postoperative irradiation also has its pro-

ponents and critics. Most clinics employ it extensively, some beginning when the patient is removed from the operating table. We think it is reasonable to irradiate the tumor bed with 3,000-4,000 roentgens, delivered in divided doses over a reasonable true interval. The surgical approach to these tumors should always be transperitoneal, and the other kidney should be exposed and carefully inspected. With the retroperitoneal flank approach, early ligation of the renal pedicle and handling other intra-abdominal conditions which may have caused the flank mass are difficult.

Our survival statistics are noted in Tables II and III.

TABLE II. PATIENTS DIED

1 year postoperative	21
2 years postoperative	2
3 years postoperative	1
	24

TABLE III. PATIENTS LIVING

1 year postoperative	3
2 years postoperative	2
3 years postoperative	1
4 years postoperative	1
5 years postoperative	4
	11

These are obviously not cumulative statistics. One of the most important factors in the ultimate outcome of these patients appears to be age at time of diagnosis and exploration. At the time of diagnosis, the average age of the group that died within five years following operation was 3.2 years. Those who survived one to five or more years postoperatively were, on the average 1.1 years old at the time of diagnosis and exploration. Our findings bear out other authors'[14-16] impressions of prognosis in Wilms tumors: our patient who survived longest, nine years, was operated on at the age of six weeks.

Summary

The records of forty-one patients with Wilms tumor have been reviewed. The most frequent clinical symptoms, abdominal mass, fever, hematuria and abdominal pain, are described and discussed. While eight patients have been lost to follow-up, statistics for the remaining thirty-three indicate that the earlier diagnosis is made and treatment given, the better the prognosis. Differential diagnosis and various facets of treatment are presented. With technical advances in surgery and anesthesia, and with the practitioner's increasing awareness of the diagnostic possibilities presented by abdominal masses in children, we anticipate earlier diagnosis, better treatment, and an increased survival time for patients having Wilms tumor.

Acknowledgment

The authors wish to express their appreciation to C. D. Benson, M.D., and J. H. Hertzler, M.D., who contributed many cases to this review, and who have given encouragement and advice to this study.

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Any cancer patient who is still menstruating or has menstruated within one year should not receive estrogens, as the rate of growth of the cancerous process may be accelerated.

Management of Polyps of the Colon

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FOR MANY YEARS, polyps of the colon have been considered precancerous lesions and have been treated accordingly. More recently certain authors, namely, Spratt and associates,[6] have asserted that this is not necessarily true and thus have stimulated considerable controversy. The attitude at this clinic toward management of polyps of the colon is based on the premise that they are potentially malignant neoplasms and usually should be removed prophylactically.

Gradually we have learned to treat these lesions more effectively with sounder judgment and greater surgical safety. We have arrived at a point which lies midway between conservatism and radicality—which, we believe, furnishes adequate treatment with minimal chance for recurrence yet does not cause the undesirable results sometimes associated with more radical management.

Initially, the treatment employed was simple colotomy and polypectomy. Then subtotal colonscopy was added. Finally, as the process evolved further, multiple colotomy with total colonscopy was incorporated. The present study presents our experience up to the stage where total colonscopy was beginning to be used with regularity.

Methods and Materials

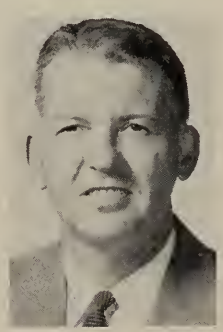
The records of 350 patients were reviewed, covering a nine-year period (1949-1957). All cases involving transrectal removal of polyps were excluded. All cases where polyps were incidental to other primary disease of the large bowel were omitted. This left eighty-six cases of polyps of the colon for consideration.



Authors

CHARLES H. HAMILTON, M.D. *(left)*

JAMES A. FERGUSON M.D. *(right)*



A follow-up period of three or more years was possible in this group. Ideal follow-up was considered to be annual clinical examination (sigmoidoscopy) and barium enema x-ray of the colon. A certain number of patients who did not fulfill the ideal criteria were contacted by letter. These reported their state of health, as well as significant symptoms relative to their previous treatment.

Data on treatment, pathology, morbidity, mortality, and follow-up were tabulated and studied.

There were forty-one females and forty-five males in the total group. Age range was from sixteen months to eighty years with an average age of forty-nine.

Treatment

(See Table 1)

The patients may be conveniently divided into two groups based on method of treatment. Members of group A were treated with segmental resection; group B, with colotomy and polypectomy or certain modifications thereof.

Group A.—Seventeen patients were treated with segmental resection and primary anastomosis. This therapy was utilized when one of three conditions was present: (1) Large, sessile lesion. (2) Large or suspicious-appearing pedunculated lesion. (3) Multiple polyps in a segment.

Group B.—Sixty-nine patients were treated with colotomy and polypectomy or one of its modifications. Fifty-three had single colotomy and polypectomy. Seven had multiple colotomy and polypectomy. Six had multiple colotomy, polypectomy and subtotal colonoscopy. Nine had multiple colotomy, polypectomy and total colonoscopy. Six of these procedures were reoperations for subsequent polyps.

Technique of polyp excision was rather standard and details need not be mentioned here.

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TABLE I. POLYP LOCATION, TREATMENT AND PATHOLOGY

Patient Groups	Polyps		Anatomical Segment	Operation	Pathological Diagnosis		
	Single	Multiple			Benign Adenoma	Malignant Adenoma (Non-invasive)	Malignant Adenoma (Invasive)
A. Segmental resection 17	9	8	Cecum and ascending—4 Transverse—5 Descending—5 Sigmoid—9 Hepatic flexure—1 Splenic flexure—1	Right colectomy—2 Transverse colectomy—3 Left colectomy—3 Sigmoid resection—8 Hepatic flexure resection—1 Splenic flexure resection—1 (Total or subtotal colonoscopy was performed in 3 patients coincident with segmental resection.) (One patient had multiple colotomy, polypectomy, and total colonoscopy 6 years after sigmoid resection.)	11	7	1
B. Colotomy and polypectomy 69	60	15	Cecum and ascending—3 Transverse—10 Descending—8 Sigmoid—62	Colotomy and polypectomy (single)—53 Colotomy and polypectomy (multiple)—7 Colotomy and polypectomy with subtotal colonoscopy—6 Colotomy and polypectomy (multiple with total colonoscopy)—9	53	22	0

Pathology

(See Table I)

In the segmental resection group there were nine cases of single lesions and eight cases of multiple lesions. Eleven cases yielded benign specimens and eight, malignant ones. Of the eight malignant polyps, seven were restricted to the body of the lesion. Only one had invaded the stalk.

In the colotomy and polypectomy group, lesions were single in sixty cases and multiple in fifteen. There were fifty-three benign specimens and twenty-two malignant. Of the latter number, all were classed as noninvasive.

As expected in both groups, the majority of polyps were located in the sigmoid area. The remainder were scattered throughout the colon being about equal in incidence in descending and transverse segments and most infrequent in the ascending and cecal region.

Results

(See Tables II and III)

There were no operative deaths in the entire series. Seven patients suffered complications most of which occurred in the early postoperative period. Two patients in the segmental resection group developed anastomotic difficulties. One required early postoperative cecostomy for anastomotic edema. The other required resection of the anastomotic site two years later for inflammatory stricture. Five patients in the colotomy and polypectomy group experienced wound complications; four, infection; and one, dehiscence. A hernia later developed in one of the four with wound infection.

Reoperation for polyps was necessary in eight patients, two from the segmental resection group and six from the colotomy and polypectomy group. A nineteen-year-old girl was treated with transverse

TABLE II. OPERATIVE MORBIDITY AND MORTALITY

Patient Group	Complications	Mortality
A. Segmental resection—17	Partial obstruction due to anastomotic edema (requiring early postoperative cecostomy)—1 Anastomotic stricture (late) requiring resection—1	0
B. Colotomy and polypectomy—69	Wound infection—4 Wound dehiscence—1	0

TABLE III. FOLLOW-UP DATA

Patient Group	Living Without Recurrence			Recurrence	Other Polyps Subsequently Discovered	Deaths		Lost to Follow-Up
	3-5 Years Post-operative	5-10 Years Post-operative	10+ Years Post-operative			Of Polyp Disease or Carcinoma	Other Disease	
A. Segmental resection 17	6	9	2	0	2	0	0	0
B. Colotomy and polypectomy 69	16	29	4	0	6	0	6	14

colon resection four years after having undergone right colectomy, both for multiple polyps. A thirty-eight-year-old woman underwent multiple colotomy and polypectomy with total colonoscopy for multiple polyps six years after having a sigmoid resection for a malignant polyp. Three patients required repeat colotomy and polypectomy for polyps which developed in segments distant from the original sites. Three others were subjected to repeat colotomy and polypectomy for lesions that occurred adjacent to the original sites. None of these was proved to be a recurrent lesion.

In the segmental resection group, all seventeen patients are living with no evidence of recurrence from three to thirteen years after operation. In the colotomy and polypectomy group, forty-nine patients are living without recurrence. Six are dead of disease other than polyps or cancer of the bowel, and fourteen are lost to follow-up. Death was due to breast cancer in one patient after six years' follow-up. Four died of cardiovascular disease after one year's, seven years', eight years' and six years' follow-up. One patient died at age ninety of diabetes and its complications nine years after sigmoid colotomy and polypectomy.

Discussion

Many different viewpoints are expressed in surgical literature regarding treatment of polyps in the colon. These range from conservative to radical. We have strived to develop a surgical philosophy toward this problem which is consistent, effective, and safe.

Swinton[8] and Turnbull[9] have shown in separate studies that polyps in the colon (even histologically malignant ones) can be adequately treated by colotomy and polypectomy. Turnbull comments on the unreasonably high mortality rates in some hospitals with major resections for polyps. Spratt and associates[7] state that the size of the polyp is the best indicator of potential malignancy and therefore can be a sound guide for treatment. They contend that excision of polyps less than 1.5 cm. in diameter must be accomplished with a mortality rate of less than 1 per cent, or the surgically induced death rate exceeds the chance for malignancy in the lesion. For polyps of larger size, the probability of malignancy is significantly greater (9 to 12 per cent in lesions from 1.5 to 2.5 cm. in diameter) and resection and its attendant morbidity and mortality may be justified. These figures are compatible with those in Grinnell's[4] extensive study of polyps.

Some surgeons assert that total or subtotal colectomy should be performed for scattered polyps of the bowel. We contend that there is unjustifiable morbidity inherent in such extensive procedures and that end results are no better than with colotomy and polypectomy. Deddish[2] holds this viewpoint but recommends segmental resection in the case of polyps in the right colon where cecal lesions may be missed more easily on follow-up x-rays.

The operative mortality for colotomy and polypectomy ranges from 0.5 per cent to 1 per cent in several large series (Bacon[1]—0.7 per cent for 252 cases; Grinnell[4]—0.5 per cent for 217 cases). In comparison, segmental resection of the colon for various diseases ranges from 3 to 7 per cent. Segmental resection should be utilized for certain lesions of suspicious appearance or for large, sessile polyps. We do not believe it should be used in preference to multiple colotomy and polypectomy for scattered polyps or for multiple polyps restricted to any main segment of colon.

We have not found our complication rate to be as great as that reported by Kleinfeld[5] after colotomy and polypectomy. It was clearly stated in a previous paper[3] from this clinic that meticulous preparation and a systematic approach will hold complications to a minimum in this procedure. Minimal morbidity was noted in a group of fifty patients on whom multiple colotomies and total colonoscopy were done.[10] Our continuing impression is that there will be no significant increase in morbidity.

There is a wide area here for critical surgical and medical judgment. The patient's clinical status must be carefully balanced against necessity for removal of polypoid lesions. False urgency must be curbed in cases where the risk does not justify the operation.

Finally, the importance of diligent regular follow-up examinations must be emphasized. Patients with known previous polyp disease should be seen annually for both clinical examination (sigmoidoscopy primarily) and barium enema x-ray of the colon. In this way, significant lesions may be diagnosed and treated at a stage when they are curable.

Summary and Conclusions

1. Eighty-six patients requiring operations for polyps of the colon have been studied to assess efficacy of treatment.

2. We are of the opinion that colotomy and simple polypectomy together with total colonoscopy is the treatment of choice for the majority of patients.

3. Segmental resection for polypoid disease should

be reserved for special circumstances. Morbidity and mortality inherent in resection procedures may be disproportionately greater than the therapeutic accomplishment.

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Hospital Names

Even though the Smiths are America's largest family, there is only one Smith Memorial Hospital in the country—at Decorah, Iowa.

But 1,134 other hospitals bear "memorial" in their names, and 1,326 are named after individuals.

Hospitals have been given the names of people, fruits, flowers, animals, saints and "possibly a few notorious sinners," according to Elmer L. Harvey, administrator of Bellin Memorial Hospital, Green Bay, Wisconsin.

He analyzed the names of 6,786 hospitals listed in 1959 by the American Hospital Association, reporting his findings in the January 16 issue of *Hospitals*, Journal of the American Hospital Association.

Most hospitals are called "hospitals," but they also go by forty-one different names, including among others, lodge, retreat, guest house, farm, sanitarium, village, inn, preventorium, sanatorium, facility, infirmary, hall, center and dispensary.

The longest name has sixty-five letters—Primary Children's Hospital of the Church of Jesus Christ of Latter-Day Saints, in Salt Lake City, while the two shortest with eight letters each are Gateways, Los Angeles, and Ivy Haven, Newark, New Jersey.

A total of 1,043 hospitals have unmistakably religious names, Mr. Harvey said. Of these 570 are named after eighty-eight different saints, with St. Joseph, the patron saint of the sick, remembered most often—in 134 names. The House of St. Giles, the Cripple, is the name of two hospitals in Garden City and Brooklyn, New York.

Apart from hospitals named after saints, there are 473 using religious names of various kinds. For instance: Wesley, Booth, Holy Family (5), Mt. Sinai (13), Bethany (4), Trinity (14), Our Lady of Mercy (6), and Good Samaritan (31).

Poets and authors, soldiers, statesmen and politicians, doctors and nurses, explorers and industrialists have been memorialized. Nationality groups, geographical areas, rivers, animals, birds and fruit have given names to hospitals.

"Names of hospitals also may affect—for better or worse—the patients," Mr. Harvey noted. He cited Tombstone General Hospital (Tombstone, Arizona); Needles Municipal Hospital (Needles, California), Cape Fear Memorial Hospital (Wilmington, North Carolina), Healthwin Hospital (South Bend, Indiana), City of Hope Medical Center (Los Angeles), and Rising Star Hospital (Rising Star, Texas).

Among the most unusual names Mr. Harvey turned up were Our Community Hospital (Scotland Neck, North Carolina), Boston Floating Hospital (Boston), Deaf Smith County Hospital (Hereford, Texas), and finally "The Hospital" in Sidney, New York.—*American Hospital Association*, Jan. 16, 1961.

Chemotherapy of Advanced Ovarian Cancer

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THE WIDE USE of cytological methods with early detection of cervical and uterine carcinomas are improving considerably the results of definitive therapy for these cancers.[1] During the same period survival of patients with ovarian cancer has not improved.[2] However, with the invention of newer chemotherapeutic agents it became possible to palliate, sometimes for prolonged periods of time, significant proportions of patients with advanced ovarian cancer.[3-5] The experience with sixty patients, followed during the past five years, for advanced ovarian cancer in the Oncology Division of Henry Ford Hospital was reviewed to clarify the indications and to evaluate the results of chemotherapy.

Material and Results

Only patients with stage III or IV cancers—as staged by Munnell and Taylor[6] were included in this study. Patients were treated only if serious symptoms or progressive disease were present. Some patients, despite known disseminated cancer, remained free of any symptoms for long periods while their disease remained clinically stationary. The intervals between the diagnosis of disseminated disease and demonstrated progressive and symptomatic disease, "the silent interval," are tabulated in Table I. The following histologic types of tumor were encountered in these patients: thirty-three serous cystadenocarcinomas, nine pseudomucinous cystadenocarcinomas, fourteen undifferentiated adenocarcinomas and three granulosa cell tumors. The histologic type of the adenocarcinomas could not be correlated to their clinical behavior in this small group of patients and subsequently they are all classified together. In forty-three patients, clinical symptoms were due to peritoneal or pleural effusions; in three of these, at some time during their disease, clinical symptomatology was dominated by pericardial effusion. In the remaining seventeen patients, symptoms were produced by pelvic growth of the tumor with resulting vascular, ureteral, or intestinal obstruction. Lymphatic metastases, while frequently seen, never were a cause of major symptoms. Distant osseous metastases were detected antemortem only in one patient and produced no symptoms.

TABLE I. THE LENGTH OF "SILENT INTERVAL"

Interval Between Diagnosis and Disseminated Symptomatic Disease	Less Than 6 Months	6 Months to 1 Yr.	1 to 2 Years	2 to 5 Years	5 to 10 Years	More Than 10 Years
Number of patients	19	11	19	6	3	2

During the first three years of the study, when possible, only local therapy was used. It consisted of radiation, radioactive gold or phosphorus, and local nitrogen mustard or triethylene thiophosphoramide instillation. During the later part of the study, all patients with serous effusions were treated systemically. The drugs used and treatment schedules are tabulated in Table II.

Local radioactive isotopes or alkylating agents were effective in controlling peritoneal, pleural, or pericardial effusions in five out of ten patients. When the formation of the effusions were stopped by such local therapy there was usually progressive growth of demonstrable tumor and excessive scarring of serous



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TABLE II. DRUGS AND TREATMENT SCHEDULES

Drug	Usually Used Schedule	Objective Regression		No Objective Effect
		Good	Partial	
Radiomimetic agents				
Triethylene melamine (TEM®)	2.5 to 5.0 mg. in single daily dose; later smaller dosages according to patient's response. Average patient, 20 to 40 mg. Oral.	1	1	4
Triethylene thiophosphoramide (ThioTEPA®)	1 mg. per 1,000 of white blood cells in white blood count daily not exceeding 10 mg. as daily dose. Drug has to be stopped when WBC drops below 3,000. I.V.	1	2	4
Chlorambucil (Leukeran®)	2 to 10 mg. daily. Oral.	2	1	3
Cyclophosphoramide* (Cytoxan®)	2 to 8 mg./kg. of body weight per day x 6. Later according to response and toxicity. Oral and I.V.	2	3	4
Uracil mustard** (U48344)	0.03 to 0.05 mg./kg. of body weight on alternating days. Oral.	2	2	5
Other				
5-fluorouracil†	15 mg./kg. of body weight x 5 every 4 weeks I.V.	3	6	5
Vincaleukoblastine§	0.2-0.4 mg./kg. of body weight. I.V. Weekly.	—	1	2

*Kindly supplied by Dr. E. A. Hawk of the Mead-Johnson Company.
**Kindly supplied by Dr. J. B. Lawson of the Upjohn Company.
†Kindly supplied by Dr. M. J. Shiffrin of the Hoffman La Roche Company and by Cancer Chemotherapy National Service Center.
§Kindly supplied by Dr. J. G. Armstrong of the Eli Lilly Company.



Fig. 1. *(a)* A malignant effusion in a patient with serous adenocarcinoma of the ovary. Treated with nitrogen mustard to both pleural cavities. *(b)* Same three months later. No new fluid formed but severe restrictive fibrothorax developed.

membranes resulting in obstructive and restrictive symptoms (Fig. 1). The histologic examination of these membranes always showed very extensive desmoplasia around viable tumor nests (Figs. 2 and 3). This was not observed in patients on systemic chemotherapy as long as demonstrable tumors were controlled by the therapy (Figs. 4 and 5). The comparisons of survival of the patients treated systemically and locally is given in Table III. Because of the possibility that tumors which produced symptoms after a prolonged period would progress slower, we divided patients into two groups: (1) patients with symptoms developing within one year after the diagnosis and (2) patients with symptoms occurring later than one year after the diagnosis. Our data did not justify this assumption as the survival of the patients with

TABLE III. SURVIVAL OF PATIENTS AFTER THE APPEARANCE OF PROGRESSIVE SYMPTOMATIC DISEASE

Treatment Variable	Patients Developing Symptoms Within One Year After Diagnosis		Patients Developing Symptoms More Than One Year After Diagnosis	
	Number of Patients	Average Survival and Range in Months	Number of Patients	Average Survival and Range in Months
Responding to systemic therapy	15	13.5 3-39	11	12.8 3-21
Non-responding to systemic therapy	9	6.7 1-19	9	6.3 2-12
Treated locally only	6	6.8 2-18	10	4.8 1-12



Fig. 2. Pleural biopsy obtained with Vim-Silverman needle from a patient with serous cystadenocarcinoma of the ovary. The biopsy site was treated three months prior with intrapleural radioactive gold with good control of pleural effusion. Note dense fibrous tissue surrounding small strands of tumor tissue. (x 40 H. & E.)



Fig. 3. Parietal pericardium obtained from a patient with pseudomucinous cystadenocarcinoma. This patient was treated one year previously with intrapericardial nitrogen mustard for pericardial effusion. Excellent control of effusion was obtained. (x 40 H. & E.) Note a solitary clump of "healthy" cancer cells in the mass of collagen.

early and late symptoms was essentially the same. Although the number of patients treated does not allow an adequate statistical analysis of the data, it appears that patients who were treated and responded to systemic chemotherapy lived longer after symptoms appeared than other patients. The average survival of twenty-six systemically treated patients responding to chemotherapy was 13.2 months, non-responding patients averaged 6.5 months and patients treated locally only 5.6 months.

We have not observed patients failing on one radiomimetic agent to respond to another but two patients who had failed on radiomimetic agents responded to 5-fluorouracil, one patient failing on radiomimetic agents responded to Vincaleukoblastine sulfate and two patients failing on 5-fluorouracil responded to cyclophosphamide.

Discussion

In 1955 Sykes and his co-workers[3] reported eight objective tumor regressions in twenty-six patients treated with triethylene melamine. Similar results were reported with triethylene thiophosphoramide by Munnell and his colleagues,[7] and others.[4,8] Chlorambucil was also reported to be effective in treatment of ovarian cancer,[5,9] as was hemisulfur mustard,[10] and cyclophosphamide.[11,12] It appears that all commonly used radiomimetic agents produce objective tumor regression in one-third to one-half of patients with ovarian cancer. In our experience on this small series, there appears to be cross-resistance between these agents, so that patients resistant to one radiomimetic agent have not responded to others. A new pyrimidine antimetabolite, 5-fluorouracil, was also shown to produce regressions in ovarian carcinomas.[13-15] Probably because of a different mechanism of action, cross-resistance with radiomimetic agents was not observed. The same applies for Vincaleukoblastine which probably inhibits cellular growth by producing metaphase arrest in dividing cells.

The natural course of ovarian carcinoma may vary from a very rapid one to a very benign and prolonged one. Our impressions, which are based on observation of this small number of patients, are confirmed by larger series.[2,16] Since chemotherapy is effective only for a limited length of time it is wise not to start it

until symptomatic progressive disease becomes apparent. Radiation therapy to local lesions is often effective and can improve total survival of patients with far advanced disease.[16] Malignant effusions can be



Fig. 4. Serous adenocarcinoma of the ovary with large right pleural effusion. *(a)* before, *(b)* after two months of oral therapy with triethylene melamine. No local therapy.



Fig. 5. Undifferentiated adenocarcinoma of the ovary, pleural effusions unsuccessfully treated with intrapleural nitrogen mustard. *(a)* before, *(b)* after three months of therapy with 5-fluorouracil.

effectively controlled with radioactive isotopes or with radiomimetic drugs administered locally.[17,18] However, the appearance of malignant cell-containing effusions usually indicates disseminated disease which is usually not controlled by local therapy despite cessation of fluid formation (Figs. 1-3).

Prolonged and worthwhile regressions were obtained at equal frequencies with all the chemotherapeutic agents mentioned except with Vincaleukoblastine with which more experience needs to be accumulated. Because of little significant difference between these drugs in their effectiveness, the choice of drug should be determined by the relative toxicity of the agent in question. Chlorambucil and cyclophosphamide, cautiously used, rarely produce severe bone marrow depressions, and the latter one, particularly, has the advantage of relative freedom from thrombocytopenia. Until more knowledge is available about the relative values of 5-fluorouracil and of Vincaleukoblastine, these agents should be used only in patients with disease resistant to radiomimetic agents.

Summary

1. Ovarian carcinoma has an unpredictable course and, despite dissemination of the disease, long-term survivals without therapy occur. Only when actively progressive and symptomatic disease is present is systemic chemotherapy indicated.

2. Effective palliation of symptoms and possibly also some prolongation of life is possible in approxi-

mately one-third to one-half of the patients with advanced ovarian cancer.

3. Chlorambucil and cyclophosphamide appear to be, presently, the drugs of choice in chemotherapy of ovarian cancer because of their relative safety and ease of oral administration, rather than any greater efficacy.

4. Cross-resistance seems to be present between different radiomimetic drugs. Therapy with drugs with different mechanisms of action (such as 5-fluorouracil and Vincaleukoblastine) sometimes are effective in radiomimetic resistant patients.

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Atomic Medical Technique Used in Diagnosing Abnormalities

An atomic medical technique that readily reveals abnormalities in brain blood flow that may lead to brain damage from strokes has been developed by W. H. Oldendorf, M.D., neurologist of Los Angeles, California.

The technique also is useful for more readily diagnosing other abnormalities of the blood vessels of the brain.

The procedure tracks the blood flow and distribution in the brain. It causes the patient no discomfort except the slight pain of the point of an injection with a small needle.

A small amount of radioactive iodine (I^{131}) is injected into an arm vein.

The amount of the iodine reaching the brain a few seconds later is measured by a pair of radioactivity counters which are positioned over the head, one over each longitudinal half of the brain.

The radioactive iodine is in a chemical form which disappears rapidly from the blood and is excreted by the body. Thus the test can be performed as often as hourly if needed, to observe changes in stroke victims or patients with other brain bloodway disorders.

Cancer and Emotions

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TREATMENT of the cancer patient splits the physician in twain. During the initial stage when he undertakes diagnosis and begins treatment, he is the very model of a scientist. During this phase the admonitions of Virkoff echo in his ears, and his vision is pervaded with pathology, organs, and ever-advancing physiochemical knowledge. His handmaidens are surgery and roentgenology.

However, in grave cases, there comes a day when the physician as scientist alone is of no value, and his role must change drastically. Now the patient is no longer a group of organ systems or a physical-chemical laboratory; he emerges rather as a tragedy-ridden human, the center of a family world of confused, anxious people, whose homeostatic balances in life have been disrupted explosively. And the same physician, who yesterday was playing so different a role, is now also friend, counselor, and smoother of troubled waters.

Here, as Franz Alexander[1] points out, is the great dichotomy of medicine, the trained scientist on the one hand, and the intuitive friend on the other. That this second face of the medical doctor can be more than intuitive and unschooled is one of the main theses which Alexander has addressed to the professions. It is also the specific purpose of the present paper in regard to the particular problem of therapy of the cancer patient. Rational approach to the treatment of the emotional disturbances associated with cancer must lie in the hands of the attending physician and not in those of a consulting psychiatrist, because these challenges are so common they cannot and should not be relegated to the sphere of specialization.

To make this type of treatment rational, the first step is observation. This means listening, since almost all people in trouble are only too happy to talk if given the opportunity. The object of this listening is to learn the viewpoint of the patient. Knowing what he sees is the *sine quo non* of dealing with what disturbs him, because in any other approach certainty must give way to speculation. In this regard the story is told of the schizophrenic patient running down the hospital corridor. He bowled over the resident psychiatrist who was trying to halt his mad flight. Since the demented man was running from a thousand hostile, but hallucinatory Russians behind him, the doctor could have known that his command to stop had a thousand to one chance against being obeyed, had he taken the trouble first to learn the facts as the patient saw them.

It is even so with cancer victims; only the patient can tell what hidden fears and strengths he has. Once these are known through listening, the physician may add to them a rudimentary knowledge of personality structure; thereupon, rational approaches to the patient's situation begin to emerge. The first such knowledge of personality concerns the function of the ego:

> Man's chief problem is to acquire enough environmental control so that the satisfactions of drives within him become possible.[2]

In regard to man's food hunger, for example, the problem becomes one of mastering the environment so that the individual can get the food which is required to satisfy his cravings. It is precisely here that the development of cancer, if perceived as a fatal threat, represents to the patient the end of his capacity to adjust. Parenthetically, threat to the capacity to get food, shelter, or even sex, is not usually the most disturbing loss posed by impending cancerous death. One physician, when dying, told his attending colleague never again to tell a patient his fate, "I cannot face leaving the love of my family."[3]

When people cannot face what they must, certain

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defenses which hide the unseeable are thrown up. Two of these mechanisms are of particular interest in managing cancer patients, the first being regression, and the second, denial.

When people use the process of regression, they slip back psychologically into childhood. By so doing they seek the protective, directive custody of their parents. Additionally, on the emotional level, they are not even living at the time of the trauma they cannot face. This is an extremely malignant mechanism, and should become the physician's prime target in any process of rational care of the whole patient. It is destructive both to the patient and his family, not to mention the physician himself.

If the patient is following this course, one is automatically presented with a person who cannot be satisfied, and who is both angry because of his frustration and demanding because of his infantile lack of self control. At the same time the physician, being the butt of such feelings, is equally frustrated and likely to react with a considerable degree of hostility toward the patient. One regressed patient called five doctors daily to demand something of each one.

When faced by any regressive mechanism, there is a strong argument for extremely careful management of consultation. The child habitually tries to exploit any rift between his parents (or parent figures) and ultimately plays one against the other. To avoid such machinations, all consultation should be funneled through one physician who acts as the patient's communications contact. Here, of course, is the traditional role of the family physician, whose knowledge of the patient neutralizes techniques for demanding and wheedling.

Another problem in regression is controllable by the doctor, this time in his relation to the family of the stricken man. Exigencies of living—for example, financial considerations—frequently tempt the therapist to delegate many functions to the spouse. This has a strong tendency to force the sick man into an infantile relationship with the wife, who, for example, may be asked to ration narcotics. This places the patient in the position where he must beg and demand like a child, thus destroying any remnant of an adult relationship remaining in the family. Perhaps this is part of the reason that Aronson[4] believes relatives often become too involved in their own guilt to perform usefully.

It is better at every point to aid the patient to use the second mechanism referred to above, denial. Sage[5] has observed that most patients do not know, but are "suspicious" that they have cancer. This is as poignant an illustration of denial as one can make. Saying that the patient is "suspicious" is a euphemism which means: He really knows, but he denies his knowledge. Such a thought is not entirely dissimilar to the one entertained by the traffic-speeding physician who well knows the danger of his situation, but who somehow persuades himself that "under these circumstances" the danger is not present.

Strangely, while helping the patient to use the mechanism of denial, the physician has a great deal of opportunity to be more honest with his patient. Should the surgeon be asked if cancer has been found during the operation, an affirmative answer can help maintain honest communications. At the same time, a form of denial is suggested to make the patient more comfortable. Thus, the experienced surgeon usually answers that the tumor was indeed found, but that extensive investigation appears almost certainly to have put the situation under control. Such a statement patently says nothing except "Yes, you have cancer," but at the same time it sounds so much like, "But we've gotten rid of it," that the patient is more than willing to accept the information.

This comment precipitates the most frequently-asked question about the cancer patient, "Should he be told?" The answer, in the light of the psychiatric formulation, is quite clear. He should be told what he demands to know, thus preserving honesty and communication. At the same time, however, the mechanism of regression is optimally forestalled while denial is sponsored, so that the patient can better deal with the truth. An observant physician will even know that under many circumstances the patient will ask the question only to request a little more double talk. If a forthright answer is not given immediately and the patient does not press for it, no further comment should be made.

When the patient asks about his disease but demands an answer, the physician should never supply the information requested unless he also offers the patient certain devices which will make it easier for him to shut out the painful knowledge. These devices include strong recommendation for activity within the patient's capacity, dissertations on the strong probability of successful eradication by the means used, and hopeful discussions of expected progress in research to meet "just such a condition as this." Also, anything which encourages good emotional relations in the family setting should be pursued. At this point, a house call to enable the doctor to survey the home situation can be of great value.

Such a program, when used by someone who exhibits any real warmth toward the patient, will do much toward keeping channels of communication open. Westberg[6] writes with great feeling about the value of communication, not only between physician and patient, but between the family and the patient. He points out that when communication is disrupted by having everyone live a series of lies, the patient becomes a lonely child who soon is both fretful and regressed. Love cannot flow from people who are constantly on guard. Contrariwise, when the truth is told, there is less isolation. In addition, if it is garnished so that there is possibility of disbelieving it, some semblance of communication can be continued. The patient's remaining life is thereby enriched.

Summary

The dichotomy of medicine has been discussed, the point being made that in treating the cancer patient, the physician at first performs as a scientist, but must always reach a place where his main function is treating the whole patient and becoming a friend and counselor to him. Under these circumstances a rational treatment must be developed on a basis of psychological knowledge. This requires that the physician be able to see the problems from the point of view of the patient as well as from an objective one.

When this viewpoint is assumed, it can be observed that the patient is threatened with a loss of control of his environment, and thereby loss of hope of any normal satisfaction. This is too painful for most humans to endure, and so they defend themselves against such knowledge. The most frequently used defenses are: first, regression, which is to be avoided; and second, denial, which the physician can help the patient to adopt. The latter is most successfully handled if the physician helps his patient to activity and thought which establish it.

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Birth Order and Mental Ills

Evidence indicating a relationship between mental disease and order of birth was reported in the January, 1961, *Archives of General Psychiatry,* published by the American Medical Association.

A study, based on a random group of women mental patients (schizophrenics) at Springfield State Hospital in Maryland, divided each patient and her brothers and sisters into the older half and the younger half to determine if more patients fell into the first half of their sibling group or the last half.

There were forty-nine in the first half and seventy-one in the last half.

The evidence "supports the hypothesis that a significantly greater number of patients was born in the last half of their sibling group," according to Carmi Schooler, Ph.D., Laboratory of Socioenvironmental Studies, National Institute of Mental Health, Bethesda, Maryland.

"The question of relationship between birth order and schrizophrenia has been revived by recently published experimental findings with normals," she commented. "These studies suggest a relationship between birth order and a primary symptom of schizophrenia, social self-isolation."

These earlier findings indicated that first-borns or only children tend to be more affiliative in an anxiety-provoking experimental situation than those who have older siblings, she said. Later-born subjects when anxious did not particularly wish to be with other people, she said.

Dr. Schooler reviewed other studies on birth order and schizophrenia, pointing out that evidence of a relationship is "especially strong when first-born and last-born are compared" although her own study showed no significant difference.

The Contribution of Peroral Mucosal Biopsy to the Diagnosis of Gastrointestinal Disease

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BIOPSY of the gastric and intestinal mucosa by means of a swallowed instrument is a diagnostic refinement of comparatively recent origin. Wood[1] in 1949 devised the first practical instrument for accomplishing stomach biopsy without laparotomy. In 1956 Shiner[2] introduced a tube capable of obtaining multiple specimens of mucosa from the duodenum and proximal jejunem. Peroral mucosal biopsy at any level of the gastrointestinal tract became possible in 1957 with the advent of the Crosby capsule.[3] More recently, the ingenuity of an increasing number of clinical investigators has produced a remarkable variety of both simple and elegant devices for the same purpose.[4-6]

In this report we wish to describe our experience with peroral biopsy of the stomach and small intestine by means of the Crosby capsule* and to evaluate the usefulness and limitations of the procedure in the light of that experience.

Materials and Methods

Seventy-one biopsies were obtained from sixty-three subjects. These included both normal individuals and patients exhibiting a variety of gastrointestinal disease. The ages of the subjects ranged from fifteen to eighty-two years. Our only requirements of the subjects were a willingness to cooperate, an ability to swallow, and an intact hemostatic mechanism.

The capsule[1] was introduced and the biopsy taken by a standard technique which we have described elsewhere.[7] For intestinal biopsies, the average time interval from activation of the biopsy mechanism to immersion of the specimen in fixative was 100 seconds. Later in our experience, when material was being submitted for electron microscopy and rapid fixation was imperative, this interval was reduced to as little as thirty seconds.

While the majority of biopsies were performed on hospitalized patients, several biopsies were safely and satisfactorily obtained from outpatients in the hospital clinic.

Specimens were routinely obtained in the fasting state. For two diabetic patients, the procedure had to be modified to conform with insulin requirements. As part of a separate project,[7] some of the subjects were given fat through the polyethylene tube attached to the Crosby capsule immediately prior to biopsy. Taking advantage of this means by which a test substance could be delivered precisely at the site of biopsy, the direct absorption of a known lipid could be demonstrated.

Mucosal specimens for ordinary diagnostic examination were fixed in formalin and processed in the usual manner with hematoxylin and eosin. Specimens obtained for the purpose of studying fat absorption or for electron microscopy were prepared by special techniques described elsewhere.[7,8]

Results

Seventy-one patients were originally selected for biopsy; only two of these were excluded because of unwillingness or inability to swallow the capsule and its polyethylene tube. Of the sixty-nine patients



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who ingested the capsule, tissue was obtained on one or more occasions from sixty-three. The biopsy procedure was carried out twice in four patients and three times in two patients. A total of eighty

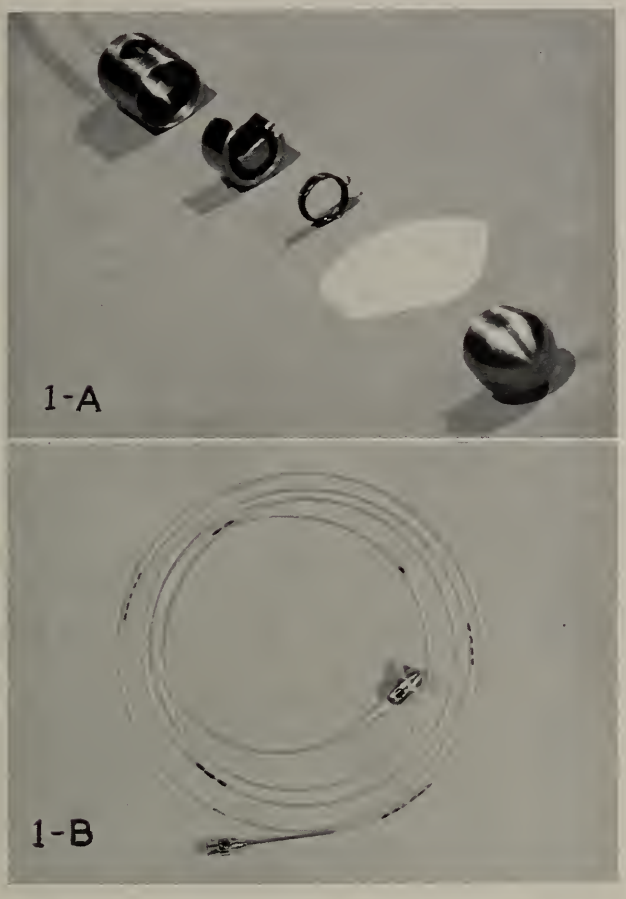


Fig. 1. The Crosby capsule. *(a)* From the top: capsule with aperture, cylindrical cutting blade, activating spring, rubber diaphragm, nose cone; all parts are disassembled. *(b)* The assembled capsule attached to 5 foot length of No. 200 polyethylene tubing.

biopsies were attempted with success in seventy-one attempts. The degree of success according to the site of attempted biopsy is enumerated in Table I.

In all but four instances (6 per cent) the quality of the specimen was quite satisfactory for diagnostic evaluation. One of the inadequate specimens was too small. Partial autolysis occurred in three specimens taken during our early efforts before we acquired facility in the prompt withdrawal of the capsule and rapid fixation of the specimen. In critical comparison, we have observed that tissue obtained with the peroral capsule is far better preserved than that obtained from the opened stomach or bowel at the operating table. Gastrointestinal mucosa obtained at necropsy is almost worthless for fine study.

In nine attempts at biopsy, no tissue was obtained. Two of these patients required nourishment during the period on intubation and ingested food particles obstructed the mechanism of the capsule. Three failures resulted from obstructing kinks in the polyethylene tubing. Retained barium from previous radiographic study blocked the tubing in one instance. Twice the mechanism of the capsule was prematurely, and inexplicably, activated. Improper assembly of the capsule accounted for one failure.

TABLE I. DEGREE OF SUCCESS OF PERORAL MUCOSAL BIOPSY ACCORDING TO SITE

Biopsies:	Stomach	Duodenum	Jejunem	Ileum	Total
Attempted	17	15	32	16	80
Successful	16	13	28	14	71

In patients with functional gastrointestinal disorders, biopsies invariably displayed normal histologic structure. In the majority of these instances, the contribution to the correct diagnosis was relatively minor inasmuch as clinical evidence was abundant and unequivocal. For three such patients, however, mucosal biopsy corrected an erroneous initial impression of diffuse, organic, intestinal disease.

Without exception, intestinal mucosal biopsy confirmed the diagnosis in eight cases of non-tropical sprue. Regardless of the segment from which the biopsy was obtained, the pathologic changes were readily recognized and were consistent with those described by others.[9,10] In these cases, it is interesting that in sprue one can often detect the absence of the normal, delicate villi by examining the fresh biopsy specimen with a simple hand lens.

For two patients with Whipple's disease, the diagnosis was unequivocally established by peroral biopsy of the duodenal and jujunal mucosa. In each of these instances, the biopsy specimens were readily adapted to the imprint technique whereby the characteristic sickle-form particles, as described by Sieracki,[11] were clearly demonstrated.[12]

Of three patients having regional enteritis, two yielded normal biopsies (in one of these the capsule did not reach the desired segment). In the third, inflammatory changes were observed, but these were nondescript and did not permit a definitive diagnosis. This experience is not surprising because regional enteritis is primarily a *sub*mucosal rather than a mucosal disease.

In six patients with primary pernicious anemia, three biopsies of the ileum and two biopsies of the

jejunem appeared normal. One biopsy of the duodenum showed mild inflammatory changes. Only one of these patients was in clinical remission at the time of biopsy.

Gastric biopsy from two patients with hemochromatosis revealed abundant iron in the basal segments of the gastric glands. A third patient was known to have abundant hemosiderosis (without hemochromatosis) in a liver biopsy; the gastric biopsy contained no iron.

Peroral capsule biopsy was attempted in six cases of subsequently proved adenocarcinoma of the stomach. Normal gastric mucosa was obtained in four. Tissue containing adenocarcinoma was obtained only once (a case of diffuse linitis plastica). In the sixth case, no tissue was extracted from the capsule; however, the aspirate from the polyethylene tube was saved and, fortuitously, yielded malignant cells in a Papanicolaou smear. These disappointing results in gastric cancer can be explained. First, a peroral biopsy tube or capsule cannot be precisely directed to a focal lesion. Often the longitudinal level in either the stomach or small bowel can be approximated with fair accuracy, but one cannot know exactly the point around the circumference of the viscus at which the aperture lies. Secondly, any instrument employing an aperture requires that the tissue be pliable in order to be aspirated; most varieties of gastric cancer are not sufficiently pliable.

No complications of the biopsy procedure were encountered in any of our patients. Infrequently, a small amount of blood was aspirated on applying suction to activate the capsule, and occult blood was occasionally detected in the stool shortly after the biopsy. But no hemorrhage of significance occurred. Tissue in the majority of specimens extended no deeper than the muscularis mucosae; in only one specimen was muscularis propria identified. No perforations, either immediate or delayed, occurred. Only one patient complained of abdominal discomfort at the time of biopsy; the cramp-like pain lasted only a few minutes and was attributed to muscle spasm induced by the biopsy.

Comment

The value of any peroral biopsy technique depends on (1) the consistency with which adequate specimens of suitable tissue can be obtained, (2) the degree to which tissue structure can be translated into reliable diagnosis, and (3) the absence of morbidity induced by the procedure itself. In our hands, peroral mucosal biopsy utilizing the Crosby capsule has met these criteria.

Adequacy of Specimens. — Seventy-one biopsy specimens were obtained from eighty attempts, a success rate of 89 per cent. In 94 per cent of these specimens, the histologic quality was excellent. These results generally parallel the experience of others. Smith and his associates[13] made sixty-three biopsy attempts in thirty-eight patients using the Crosby capsule. Of their early attempts, one-third were failures, but later this was reduced to 10 per cent. Brandborg, Rubin and Quinton,[14] using a more elaborate instrument of their own design, reported a single attempt success rate of 82 per cent in 697 biopsies at all levels of the gastrointestinal tract; this figure was appreciably improved on repeated attempts. Shiner[15] reported 214 small bowel biopsies with the device which bears her name, but she did not list the number of failures. We have found that in the small fraction of cases in which the first attempt at peroral biopsy fails, an adequate specimen can be obtained almost invariably if one perseveres in a second or third effort.

Contribution to Diagnosis.—Microscopic examination of mucosal biopsies furnished an important and often essential contribution to the diagnosis of certain disease states. Understandably, the procedure is of greatest value in diffuse diseases of the stomach and small intestine. Peroral biopsy may not provide reliable information pertaining to localized processes or focal lesions. In evaluating our results, the following point should be noted: while a normal biopsy in the presence of localized disease is obviously of little value, the finding of normal tissue where clinical, laboratory, and radiographic data suggest a widespread or diffuse process may be of real significance.

Safety.—Following the biopsy procedure in none of our subjects was there evidence of significant hemorrhage, perforation, or other untoward complication. Nevertheless, we consider it prudent to attempt the procedure only if the patient's hemostatic mechanism is intact. We have not yet had occasion to attempt a biopsy of the esophagus although such is feasible with the Crosby capsule. The absence of serosa in this segment appreciably increases the risk.

Usually a mild annoyance with the polyethylene tube and a slight gagging as the capsule is swallowed or withdrawn are the only discomforts to the patient.

Summary

Eighty peroral mucosal biopsies of the stomach and small intestine were attempted employing the Crosby capsule. Tissue was obtained in seventy-one attempts (89 per cent). The specimens were adequate for histologic examination and diagnosis in all but four instances. The diagnostic contribution of these biopsies in a variety of conditions is discussed. Peroral biopsy is most useful in the diagnosis of diffuse disease of the gastric or intestinal mucosa. The discomfort to the patient is minimal, and we have encountered no untoward complication of the procedure.

Addendum

Since this paper was submitted for publication, we have accomplished an additional sixty-six peroral mucosal biopsies with further improvement in the rate of successful recovery and with no untoward sequelae.

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Cancer Mortality Among the Foreign-born in the United States

More than 34,000 cancer deaths recorded for foreign-born whites in thirty-five states during 1950 were analyzed by country of birth of the decedent. Results for sixteen sites have been presented in the form of age-adjusted mortality ratios for migrants from twelve countries, expressed as percentages of the rates for native whites born in the United States.

The foreign-born, in general, were subject to different schedules of cancer risk than native whites. Excesses or deficits in risk were not uniformly distributed by site across all ethnic groups, but were specific for certain site and ethnic-group combinations. Several of the more striking ethnic group differences were concentrated in the upper digestive tract—esophagus and stomach—in contrast to smaller variability by ethnic group for intestines or rectum. These ethnic-group effects were not confined to any single region of the United States and most of them persisted when data for six large metropolitan areas were examined separately. The consistency of the present results with earlier American reports on ethnic group differences in cancer risk is discussed.

Some of the data on migrants from foreign countries have been compared with the results of experience in the countries of origin. Some areas of agreement and disagreement between the ethnic-group results and information on international variation in cancer mortality rates, as well as other findings on the epidemiologic characteristics of individual sites are also indicated.—WILLIAM HAENSZEL, Biometry Branch, National Cancer Institute, Bethesda, Maryland. *J. Nat. Cancer Inst.*, 26:37-132, 1961.

The Case for Keeping Track of Cancer

Harry M. Nelson, M.D.
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TO WORK effectively in cancer control we must be able to measure our progress toward success. We strive toward a goal which is removed from us at various distances: some are measured by imperfections of our skill, knowledge, technique or equipment, and some are set by lack of methods of treatment (which research must discover). There is but one way to measure our effectiveness in treating cancer: to run a continuous medical audit of cases handled and results achieved. This, in simple terms, is a cancer registry.

In 1956, when cancer registries became a requirement for American College of Surgeons' approval of cancer programs, they had already been proved able both to measure and stimulate progress in cancer control. All hospitals must have a registry to meet the requirements for accreditation.

It is unfortunate, but not surprising, that the College has required a registry in many hospitals somewhat ahead of the staff's desire to have one. After all, most physicians meet many more uncured cancer patients than cured. However, the physician who is reluctant to see himself mirrored by the registry, must come to accept it as a perspective for self appraisal rather than as a punishing reflection. Without thorough follow-up and the review of records encouraged by registries, the physician has no statistical means to refute his pessimism, which often reflects the concern of the general public. An over-all national cure rate of 35 per cent means little to him when he knows it may not reflect the record of his own hospital.

Certainly, any successful registry must be *wanted* by the medical staff, quite apart from the fact that it is required by rules of the College of Surgeons. Members of the staff must *care* to know how well the cancer problem is being managed and be brave enough to find out through reporting of and following up on all of their cases, public and private, inpatient and outpatient. The registry manual of the American College of Surgeons gives these instructions. Creating this interest is the job of the hospital's Committee on Cancer.



The Author
HARRY M. NELSON
M.D.

This means that the medical staff must be stimulated to take a lively interest in organizing and maintaining the registry. Record librarians and tumor clinic secretaries, no matter how competent, cannot be expected to handle matters of policy. They should not have to decide how to meet requirements of a good registry. For example, it is not up to them to decide who writes clinical abstracts—a physician or themselves. The Committee on Cancer must have the authority and take the responsibility of insuring full cooperation by the medical staff.

There can be no doubt that hospital registries have improved the records on cancer. They have evoked interest in this important aspect of cancer treatment in attending physicians, residents, and interns. However, the primary purpose of a registry is to provide the staff with a clear picture of how it is doing in diagnosis and treatment of cancer—not merely to prepare statistical data which are unused. It is physician participation, interest, and willingness to accept responsibility that make a registry purposeful. Therefore, a hospital registry must be under the authority of staff physicians rather than that of clerical personnel who have been instructed to meet only minimum requirements.

A successful follow-up of all the cancer patients diagnosed and treated in a hospital is dependent on the understanding and agreement of the medical staff. They must co-operate.

Finally, the fruit must be picked. The unwarranted aura of statistical mystery surrounding the grouping

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and counting of cases by age, sex, site of disease, stage, microscopic confirmation, cell type of tumor, survival time, and the like, must not be allowed to obscure the fact that simple arithmetic and common sense prevail very well. The important 10 per cent of the job is in the selection of various categories and relating them properly to each other, even though 90 per cent of the time is spent in categorizing and counting.

Comparison, after all, is what we seek from the registry; we want to know how one technique compares with another. Only by comparison can we tell good from bad practice in the hospital, and the need for comparison in cancer control does not stop at the individual hospital's walls.

Hospitals must compare results and exchange ideas. This need is answered by the *central registry* which functions in an area or on a statewide basis. Facts as they exist must be available for comparison to advance control activities locally, regionally, and nationally.

The *central registry,* supported by many fully cooperating institutions, affords us the best means to learn the magnitude of the cancer problem and to compare effectiveness of control measures. A central registry is, of course, the sum of its parts. To produce significant information, it must work from data compiled by standard means. Criteria must be set for forms, definitions, reporting techniques, and operating procedures; and all participants must conform to established patterns. The central registry cannot exist without such agreement, and the individual registry will certainly benefit. Working with uniform data, the central registry can serve as a clearing house for the follow-up of cancer patients and it can compile and analyze cancer statistics for the individual hospital as well as for the area. The experience of the central registry staff is also helpful to those charged with maintaining the registry program of member hospitals.

Obviously the central registry, if it is to be successful, must have the complete backing and active participation of all organized medical groups. A committee representing these groups must give counsel and guidance in setting policy and rules for the collection, maintenance, use, and final disposition of cumulative records. This committee must also keep the registry free of potential legal snarls involved in reporting information. To achieve this immunity, there must be prior agreement on the handling of patient records, and similar agreement on the identification of participating hospitals in the registry's reports.

We believe that central registries will contribute better cancer control all over the United States. An ultimate objective of effective cancer control is compilation and publication of complete information. A central registry answers this need because it assembles and pools information concerning the characteristics, diagnosis, and treatment of persons with cancer from various sources. It serves as a repository for records of cancer in a region and also provides an effective system of follow-up which helps participating hospitals. In most areas it serves as a clearing house for mortality data. Certainly one of its most important functions is that of furnishing consultation and assistance to hospital registries. It prepares statistical analyses from accumulated data so that cancer care in each local hospital can be compared with over-all regional experience. A central registry advances our knowledge of the epidemiology of cancer. It can, in many instances, suggest avenues for laboratory and clinical research. Uniform reporting of data about cancer and improved record keeping are fostered.

A central registry may be organized in a county, a state, or a region. Successful county registries operate in Calhoun County, Michigan and Westchester County, New York. Among the state registries that are contributing important data are those in Massachusetts, Connecticut, California, and New York.

Most central registries are operated by a medical society, a medical school, a voluntary health organization (such as a division of the American Cancer Society) or a governmental agency like the state health department. The offices of such registries are usually housed in these organizations, and are supported by a combination of organizations. Their success is dependent upon complete cooperation. The Calhoun County Registry in Michigan is operated by the Calhoun County Medical Society in cooperation with the County unit of the American Cancer Society and the County Health Department. The American College of Surgeons and the American Cancer Society are now in a position to assist any area in developing central registries as a part of the whole cancer registry program.

The problems and uncertainties created by hospital and central registries can be overcome by the interest, cooperation, and participation of the responsible committees. But these problems are as nothing compared to the prospect of a disease that might otherwise continue to cut down well over a quarter million Americans yearly without leaving a tell-tale path.

The lack of adequate data on the distribution of cancer in different populations is one of the great handicaps confronting cancer research. At present, only a relatively few nations have developed an adequate statistical profile of the cancer problem. The United States is not one of them. The Cancer Prevention Study of the American Cancer Society will help, during the next six years, in gathering epidemiological information in the United States on cancer as it is related to place, occupation, habits, diet, and many other factors.

However, there is no doubt that hospital and central registries must be looked to for vitally important insights into the epidemiology of cancer. Working together, these registries can help turn the dreadful toll of cancer into a bell that will guide our research and our treatment up the right paths to conquest.

A Central Statistical Registry has as its purposes and functions:

1. To collect and maintain a file of case history abstracts of all cancer cases diagnosed or treated in the participating hospitals.

2. To stimulate and to assist in the development of hospital cancer registry programs in the accredited hospitals participating in the program. (Participation in the Central Registry Program by the hospitals will be contigent upon well organized and functioning hospital registries).

3. To provide to the participating hospitals such follow-up information on their reported cancer cases as may be available from state vital statistics records (death certificates), and reports from other hospitals. (Primary responsibility for the follow-up of individual cancer patients rests with the hospitals and physicians concerned with the patients' care).

4. To prepare over-all statistical analyses and evaluations of the cancer data accumulated, as well as comparative audits for the participating hospitals as the need arises and the situation warrants.

5. To maintain and make available for use, as may be needed, the file of clinical and follow-up information on cancer patients for such pathological, clinical, or other special studies as may be recommended or authorized by the Board of Trustees of the Michigan Cancer Registry.

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Pathogenesis of a Virus-induced Leukemia in Mice

Male BALB/c mice that received a cell-free extract from the spleens of mice with leukemia induced by a virus were compared with BALB/c mice of the same age and sex that received a cell-free extract from normal spleens. Untreated BALB/c mice were used as controls. Mice six weeks of age were chosen for the injections, since tissues from newborn mice are hard to handle, and a relatively low dose of virus was given to insure a gradual development of leukemia.

No difference in the three groups could be detected until eight weeks had elapsed, when many megakaryocytes containing granulocytes were observed in the bone marrow of the virus-injected mice. The next difference detected was a gradually increasing hyperplasia of the spleen in the virus-injected mice.

A few mice showed a localized reticulum-cell hyperplasia in the lymph nodes. The most significant alterations appeared to be in the thymus, and, with one exception, it was in this organ that leukemia was first recognized in the treated mice. The thymus in one leukemic mouse did not contain malignant cells but showed a granulomatous reaction. A series of transplants made from the primary leukemias resulted in lymphocytic neoplasms with different biologic characteristics in regard to growth period, spread from the site of inoculation, and organ involvement.

The transfer of tissue from hyperplastic spleens from mice with no morphologic evidence of leukemia reproduced the same sequence of preleukemic lesions that were observed after transfer of the cell-free extract. This study indicates that inoculation of the leukemia-inducing virus causes a derangement in certain reticular organs of mice which is conducive to the development of lymphocytic neoplasms. The virus described by Moloney may be acting like many other carcinogenic agents. Several incidental lesions appearing in experimental, control, and stock BALB/c mice are described.—Thelma B. Dunn, John B. Moloney, Arleigh W. Green, and Betty Arnold, Laboratory of Pathology and Laboratory of Biology, National Cancer Institute, Bethesda, Maryland. *J. Nat. Cancer Inst.*, 26:189-221, 1961.

Isolation-Perfusion and Infusion Methods In the Treatment of Cancer

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In 1946, nitrogen mustard compounds were introduced into clinical medicine for the treatment of malignant neoplasms. At first, these radiomimetic agents were used primarily against neoplasms of the hematopoietic system. During the past few years, they have been used with increasing frequency against solid tumors. Unfortunately, all of the effective cancer chemotherapeutic agents are potentially toxic. Because of the narrow margin between effective dose and intolerable toxicity, available compounds are far from ideal. Isolation-perfusion (regional perfusion) and infusion techniques are attempts to increase the effectiveness of these imperfect agents.

Isolation-Perfusion

Originated by Creech and his co-workers, isolation-perfusion methods are based on isolation of the circulation of a region of the body and perfusion of the isolated circuit with a chemotherapeutic agent via an extracorporeal circulation. An oxygenator is included in the extracorporeal circuit because of data suggesting that high oxygen tensions increase the effectiveness of some chemotherapeutic agents.

A most important principle underlying these procedures is that of confining an intra-arterially administered chemotherapeutic agent to a tumor-bearing region. This confinement allows high local concentration of the agent while decreasing systemic toxicity. Although none of the present methods permits complete vascular and lymphatic isolation, the extremities and the lungs can be perfused with little escape, or leakage, of chemotherapeutic agent into the systemic circulation. In general, isolation-perfusion of the extremities is safe, but the high sensitivity of normal pulmonary parenchyma to nitrogen mustard compounds makes most surgeons reluctant to apply these techniques to patients with neoplasm of the lung. Regional perfusion of most other regions is accompanied by a variable but often significant leakage of chemotherapeutic agent. Such leakage may produce systemic toxicity and decrease the high regional concentrations presumed necessary for tumoricidal action.

Selection of Patients.—Proper selection of patients is difficult because response to isolation-perfusion is unpredictable. Although other tumors have regressed after isolation-perfusion, the best results have been reported after treatment of patients with melanoma, rhabdomyosarcoma or liposarcoma.

At the University of Michigan Medical Center isolation-perfusion procedures are now limited to patients with melanoma or sarcoma. Further requirements are (1) that the neoplasm is unresectable but regionally confined, (2) that the neoplasm involves an extremity, the face, or upper part of one side of the neck, (3) that radiation therapy is not advisable, and (4) that the patient is thought able to tolerate a major operation.

Technique.—After freeing the appropriate artery and vein, 2.0 mg. of heparin per kilogram of body weight is administered intravenously. The artery and vein are cannulated. The extracorporeal circuit, consisting of a disposable bubble oxygenator and two pumps, is primed with 750 ml. of blood warmed to body temperature. Arterial pressure in both the systemic and the perfused circuit is measured using intra-arterial cannulas, pressure transducers, and recorder. Appropriate vascular clamps and tourniquets are applied and the tumor-bearing region perfused from the extracorporeal circuit. The rate of blood flow into the perfused region is adjusted on the basis of the patient's ideal weight, the mass of tissue perfused, and the arterial pressure within the perfused circuit. The arterial pressure in the perfused circuit is kept 20 to 30 mm. Hg below systemic pressure because this restriction appears to decrease leakage.

When venous return is satisfactory, the desired chemotherapeutic agent is injected immediately proximal to the arterial pump. If short-acting agents such as nitrogen mustard are used, four injections are made within one hour and the perfusion is then con-

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tinued for twenty to thirty minutes after the last injection. Longer-acting agents such as phenylalanine mustard are given in one injection and perfusion continued about one hour. At the end of perfusion the cannulas are removed, the heparin neutralized, and the vessels repaired.

Selection of Agents.—Nitrogen mustard compounds are used most frequently. Phenylalanine mustard is particularly effective against melanomas, possibly because of incorporation of phenylalanine into melanin synthesis.

Complications.—The most significant complication related to the technique of regional perfusion is arterial occlusion. Patients with pre-existing arterial disease or those undergoing repeat perfusion seem most liable. Other complications of the technique are persistent edema, bleeding from the arteriotomy site, and venous thrombosis. Bone marrow depression is the most serious complication caused by the chemotherapeutic agent itself. This complication is directly related to the inherent toxicity of the agent and to the amount of leakage into the systemic circulation. Less severe complications include persistent nausea and vomiting, alopecia, diarrhea, stomatitis, and nerve injury.

Results.—It is premature to attempt a critical evaluation of isolation-perfusion techniques. However, certain generalizations are probably valid. Regional perfusion is most effective when applied to lesions of an extremity. Melanomas may be expected to show a relatively high rate of response (25 to 40 per cent). Sarcomas are extremely variable in response but regress in perhaps 25 per cent of cases. Carcinomas, and particularly adenocarcinomas, respond least well. Probably as a result of direct neurotoxicity of the agent, pain is usually relieved. It is noteworthy that, to date, no cure of neoplasm has been reported from regional perfusion techniques.

Continuous Intra-Arterial Infusion

The meager results of isolation-perfusion methods in the treatment of patients with carcinoma warrant trial of other ways of increasing chemotherapeutic effectiveness. In one such attempt, Sullivan and coworkers recently introduced the use of continuous intra-arterial infusion of an antimetabolite (Methotrexate) for which an antidote (citrovorum factor) is available. Intermittent, systemic administration of the antidote permits infusion of large doses of the antimetabolite.

Method.—Present evidence suggests that continuous intra-arterial infusion is most useful in treating patients with incurable but unilateral squamous cell carcinoma within the distribution of the external carotid artery. The ipsilateral external carotid artery is cannulated with a plastic catheter. During each of the next seven days, 25 mg. of Methotrexate in 1000 ml. of isotonic saline is slowly pumped (infused) into the artery. Six mg. of citrovorum factor is given intramuscularly every four hours during the course of Methotrexate to neutralize the latter's systemic toxic effect.

During these seven days the patient may well have pronounced shrinkage of the tumor; however, he may develop an ulcer in the buccogingival region and this is a signal for immediate cessation of Methotrexate. It is unlikely that the patient will develop bone marrow depression, but serial blood counts are always obtained because more than lethal doses of Methotrexate are given.

It is probable that within three months after cessation of therapy the squamous cell lesion will start to progress again. Therefore to permit retreatment, the arterial catheter frequently is left in place with the sealed end buried subcutaneously.

Results.—In most patients with squamous cell carcinoma who are treated with continuous intra-arterial infusion, there is some regression of tumor in the area of infusion, but no regression even immediately outside the infused arterial bed. Disappearance of all clinically detectable tumor occurs in some patients, though this disappearance has been short-lived in our modest series.

Discussion

The requirements for optimum regional perfusion are still being debated and investigated. The most important unsolved problems are those of the desirability of high oxygen concentration in the perfused circuit, the significance of leakage as measured by isotope and dye dilution techniques, and the optimum perfusion rate for the isolated circuit. Other unanswered questions include the efficacy of chemotherapeutic drug combinations, the value of altering metabolic rate, and the protective influence of hypothermia during regional perfusion.

The applicability of continuous intra-arterial infusion to regions other than the neck, to tumors other than squamous cell carcinoma, and to the use of other agents which can be neutralized, is under investigation at several institutions.

Investigational vs. Practical Chemotherapy

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A RECENTLY noted sign erected by a chiropractor on a Detroit street denotes "chiropractic as the *safe* way to health."

Consider how many toxic, allergenic, seriously-depleting, fundamentally-deranging agents are used in medical practice today: digitalis, butazolidine, nerve-damaging antibiotics, phenothiazines causing bone marrow and liver damage, hypotensive agents of great power, penicillin and other potent allergens; the terribly effective oral diuretics and the extremely potent corticoids.

Consider how many persons have been severely disabled, prolongedly bothered with itches and rashes, chronically weakened, or disoriented, or nauseated by our new and non-official remedies. Consider how many have died, or heard or read of others dying from the use of these remedies.

Consider the morbidity and mortality of our extended surgical and radiological reach.

Overly vigorous medical treatments and overly ambitious use of the knife and of more primitive cauteries than radiation sent several generations of Europeans stealing off to irregular healers in the past.

The medical arts of our times suffer more from their excessive power, than from any other factor. People with good sense have always been, and always will be, a little afraid of physicians and much afraid of surgeons.

If this reasonable fear is not to be increased by further accumulations of evidence, we must all learn to become more patient in awaiting results, and more conservative in the number of things we prescribe and the risks we encourage patients to accept in the treatment of minor disabilities and discomforts.

How, then, shall medicine progress? The new must be tried. But it must be tried only for serious reasons by seriously interested and experienced students of drug action and toxicity; who are equipped with an optimum of time, instrumentation, technical and laboratory support in their evaluation task; and who will see it as their clear duty to make their observations in an unbiased fashion, and to report them thoroughly, promptly, and objectively, to their colleagues through various means created for the exchange of scientific information by professional societies.

Persons receiving investigative drugs should realize the nature of their treatment. Where possible, it ought to be publicly apparent that they are under such study.

The investigational chemotherapist, whether he be concerned with infectious, psychiatric, or neoplastic disease, should be recognized as having a special duty to perform for his profession in addition to that which he already has to perform for his patient. And his patient is his *patient*, not his subject.

When everyone does investigational therapy, nobody does conventional therapy. The result is a totally inexcusable, massive multiplication of human injuries, misfortunes, sufferings and deaths over that already deeply-regretted, irreducible minimum of therapeutic misadventures which appear to be the inevitable cost of medical advancement.

If we love our profession, we must be prepared to leave the dubious glory of having been the first practitioner to give a dose of the chemist's last invention to some one who would rather do that than make a living.

Trouble comes when this latter idealist starts talking directly to the public instead of only to us; or smugly insinuates that because he is always trying new things which only rarely succeed, he is the best man to come to for genuine medical management. Along with frequently succumbing to these sins, the investigative chemotherapist is also tempted to make his efforts look as productive as possible. Hence, no reports are ever as good on anything as the first one was.

The investigative therapist can spoil the whole play for everyone—the patient, the profession, and himself by such failings.

It is incumbent, therefore, for the investigative therapist and the conventional therapist, each to have a clear idea of his own duties and capabilities and to work with his fellows in sincerity and unity of purpose. This is the true "safe way to better health."

Presented at the Michigan Clinical Institute, Detroit, March, 1960.

Sixty Years of Medical Practice

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TODAY is April 12. In twelve more days, it will be the 24th—the sixtieth anniversary of my starting the practice of medicine in Detroit. As I think over these years, I can say with Ovid in his Tristra, Book III: "My home, the city, and the image of well-known places pass before my eyes."

It has not been an easy thing to know what to say on an occasion like this. Dr. Henry K. Beecher of Harvard Medical School said in his article on Anesthesiology, printed in *Seventy-five Years of Medical Progress*: "It is a good thing to look back from time to time in order to get our bearings. We can hardly know where we are going unless we know whence we came, lest we end up where we started. . ." In previous talks and papers, I have told about Detroit and its medical schools, hospitals, doctors and surgical practice in the old days and without repeating myself, some reference will be made to earlier times.

I was born on December 25, 1876, the 100th anniversary of the founding of our country. It seems to me, as I have studied medical history, that my lifetime has been spent in the Golden Age of Medicine. During this short time, we have had an opportunity to watch and marvel at the wonderful growth of medical knowledge. Dr. Louis H. Bauer, Editor of the book, *Seventy-five Years of Medical Progress, 1878-1955*, states in the Foreword:

> "During this relatively brief period of time—little more than the span of an ordinary life-time in these days of increased longevity—medical scientists have learned more about the nature and treatment of disease, and about its prevention, than in the previous 3,000 years."

Especially in the last twenty years, new discoveries and theories, new drugs—the number of which is bewildering to the practicing physician—new treatments, and new methods are presented to us almost daily in the many medical journals. They are discussed in papers presented in our medical meetings, or described to us by the detail man. It is almost impossible to keep abreast of them all. The prescriptions we write today were unheard of when I started in the practice of medicine. In fact, some of the most prevalent diseases of that day are little seen today—typhoid fever, diphtheria, scarlet fever. Pneumonia was treated with digitalis, the open-air treatment, whiskey and quinine. Tuberculosis was treated with eggs, milk and rest. People resisted going to a sanatorium. In fact, in the old days people went to a hospital only as a last resort. They thought they were surely going to die if the doctor recommended hospital treatment. The suggestion by the doctor of hospitalization often meant the loss of the patient. He would try another doctor first.

In 1955, in a paper entitled "Looking Back Fifty-five Years," I ended a list of the high spots of medical practice up to that time with the Salk vaccine. During the last five years, according to the annual edition of the Encyclopedia Britannica, the main high spots in medicine have been the tranquilizers, the work on an oral method for the treatment of diabetes, the increased interest in medical rehabilitation which is being studied more and more, the use of television in medical teaching, the controversy regarding cholesterol in high blood pressure and coronary thrombosis, continued research on antibiotics, the development of new drugs, increased work in heart surgery (in which Detroit surgeons have been pioneers), the controversy regarding the role of cigarettes and air pollution in lung cancer, and of course, paramount is the continued search for a cure for cancer. Biochemistry and genetics (unheard of words in my early medical training) are coming to the fore. One of the discoveries of great value, as we know, has been the use of polyestic fibre to make artificial arteries to replace eroded hardened arteries in certain types of heart disease. And, of course, there is that then undreamed of thing—space medicine. The Nobel Prize was awarded in medicine to Severo Ochoa and Arthur Kornberg for their work in the field of enzymes. These basic discoveries advanced the knowledge of genetics, and it is hoped that they may yield the clues to various diseases, of which the cause is now not known. There are the work in geriatrics and the efforts to solve the problems of old age. Another matter which, as we all know, is being debated is the question of more medical schools so that we may have an adequate number of physicians. I could go on and on with this list of highlights of recent medical advances.

But let us go back—for I would like to tell you

Delivered at a meeting of the Detroit Academy of Medicine, Detroit, Michigan, April 12, 1960.

about the reputation that Detroit held in the medical world at the beginning of the century.

In the early days of my medical life, I always liked to go to the meetings of the AMA. They were not so large in those days, and one became acquainted more easily with other doctors. One thing that irritated me was the following: You would meet a doctor and start talking. Then came the question, "Where do you practice?" "In Detroit" would be my answer. There would be a pause. "Oh, Detroit! That's the place where doctors make a lot of money but never contribute any scientific material to medicine." Another man said, "There isn't a Detroit doctor on the program." Such was our reputation. Today, of course, the situation is just the opposite. Detroit today is a recognized medical and research center. What has caused the change?

In my lifetime, I have had three dreams. Thoreau wrote in his "Walden": "If you have built castles in the air, your work need not be lost; that is where they should be. Now put the foundations under them."

The first of my dreams was in relation to the Wayne County Medical Society. In my early days, I was secretary-treasurer of the Society. We had no home of our own. Meetings were held in the old County Building, the Elk's Temple, the old Prismatic Building on First Street, in various hotels, and sometimes even in the doctors' homes. As secretary-treasurer, it was my job to arrange the programs (after consulting with the president, of course). Then I had to have the announcement postcards printed and mail them. I kept all the records, paid the bills, collected the dues. I was bonded for $500. This will show you how small the Society was. Looking back over the years, it is hard for me to realize what has happened to our County Society. From a small group of doctors without a home, we have grown gradually through the years to over 2,600 members. One has only to look at the *Detroit Medical News*, when the annual report is printed, to see what has happened. Look at the list of committees, the many services offered to doctors and to people in need of medical help. So my first dream has come true, due to hard work on the part of many dedicated doctors. One would like to list their names, but it would be impossible to mention them all. We now have this fine and complete building, with an auditorium, meeting rooms, dining facilities, the Beaumont Historical Room, and so on. One must not forget also to pay tribute to the David Whitney family for their generous aid to our Society.

Medicine has been organized in the Wayne County Medical Society. The latest in medical discoveries is reported to us. Only recently, the Beaumont Lecture for 1960 discussed "Pulmonary Changes Induced by Inhaled Substances, Pathologic Cardiopathies of Occupational Origin," a subject researched at Wayne State University College of Medicine. And so the Wayne County Medical Society has been a factor in the fact that Detroit is no longer unrepresented at national and international medical meetings.

My second dream was that Detroit would some day have an outstanding medical school. Looking across the campus you can see that that dream also has come true. That new medical school building represents, as does our Medical Society building, a tremendous amount of work and dedication.

I think back to my own medical school days when ours was the first four-year course and we had no course in laboratory pathology or physiological chemistry. There were only four microscopes for our whole class to use in our so-called course in bacteriology, which was just beginning that year to be part of the medical curriculum. The old anatomy dissecting room with its never-to-be-forgotten smells, which drove me to smoking a pipe, bears no comparison with the anatomy laboratory of today. The teaching was mostly didactic, plus what knowledge could be picked up from witnessing operations and in the O.P.D. where students quizzed patients and reported their findings to doctors who, in turn, quizzed students.

There was no internship, as such, in those days. You graduated, and opened your office the next day. I had a sort of internship by working at the old Detroit Emergency Hospital where the insane, would-be suicides, the man suffering from delirium tremens, and all the other sick poor were brought. Now every medical student serves, as a matter of course, an internship and probably a residency in a well-equipped, modern hospital. The medical college is affiliated for teaching purposes with Detroit Receiving Hospital, with its out-patient and research departments in the Farwell Annex, with Children's Hospital, Herman Kiefer Hospital (a far cry from the so-called "Pest House" in which infectious diseases were cared for in the old days), Veterans Administration Hospital, Wayne County General, Harper, Grace, Detroit Memorial, and so on. Then there are the Kresge Eye Institute, the Lafayette Clinic, the Rehabilitation Institute of Metropolitan Detroit. To care for the needs of an industrial city of this size, there is in the Medical College the Department of Industrial Medi-

cine. There is a Department of Neurosurgery and Neurology. One could go on and on. It is a joy to see what happened to a school which at one time stood on shaky ground. No longer the Detroit College of Medicine, it is known as the Medical College of Wayne State University. This too, was due to the work of devoted men who came to the rescue of the school in its need, and to the loyal support of its Alumni Association. Among these men are members of our Academy.

We have mentioned one of the fields in which research is being done at the medical school—the subject of the Beaumont Lecture for 1960. We shall mention only two others of the many—the work on cerebral vascular disease, and the research on heart metabolism. This fine, well-equipped medical school, administered and staffed by leaders in their specialties, is another reason why Detroit is known, and well known, wherever the results of medical research are being presented to the medical world.

You have all read in the papers about the proposed new Medical Center which will include Harper, Grace, Women's and Children's Hospitals, with other buildings and facilities to make it a great center for the study of disease. This is in the future, but we hope for its success.

My third dream was to have an up-to-date medical library. As you all know, our present building on Mullett Street is bursting at the seams with its collection of books. It is really remarkable how the staff members are able to do the job they do with the present facilities. The men who made possible the Wayne County Medical Society building and our new medical school building will no doubt make my third dream come true. The lack of an adequate library is the only criticism regarding our medical school—the only thing the authorities say is necessary to complete our medical center.

I would like to say a word about our Academy. In the "Introduction" to the Year Book of the Detroit Academy of Medicine, we note the following which may be of interest to present-day members of the Academy. It states that the Academy was much interested not only in the development of closer professional and social relationships among portions of the Detroit profession, but also in other developments.

"Doubtless, the organization of the Detroit Medical College in 1868 was the underlying stimulus of this effort to secure intellectual, social and professional training from this band of professional workers. The teachers in this college were practically all new men in the work; some felt the need of outside aid to render their work most successful. Those were most active in promoting the Academy. Active members of Michigan College of Medicine and Surgery and the Michigan College of Medicine as well as the Detroit Medical College.

In the conduct of other medical societies, hospitals, elevation of standards of medical qualification for practice, in the struggle for the betterment of the profession in Michigan and the United States, men trained in the Detroit Academy of Medicine have taken an important part, as published records abundantly prove."

This is still true today. The Academy has as members some of the leading men in the various specialties, men who take an active part in the work of the Medical Society and of the medical college. We are proud to be members of the Detroit Academy of Medicine.

With all our advances in medical knowledge, we find that present-day medicine is re-examining some of the ideas of the old days, and now and then selecting a worthwhile one for study. There is a movement afoot in my own fraternity, for instance, to bring back, to some extent at least, the old preceptor system.

The tremendous need for physicians has led some schools to plan a shortened pre-medical course and to try out the admittance of specially talented students to the medical school directly from high school. The medical curriculum in some instances will be revised and shortened in an experiment to try to graduate students in six years rather than in eight. We shall watch these experiments with interest.

An article which bore no author's name appeared recently in a magazine and I clipped it. It seems to epitomize just where we stand in medicine today, and I would like to quote it:

SOMETHING TO THINK ABOUT

"When one pauses to reflect that more has been achieved in medical fields in the last two decades than in all previous recorded time and that most of the fascination, investigation and excitement still lies ahead, one realizes the importance of passing this heritage on to other coming generations; that this is more important than possible Assurances of Social Security, luxurious living standards, or greater leisure.

"One of the concepts which the future may have difficulty in preserving amidst the routines of Big Government, organized labor, professional management and automation is the eternal significance of the individual human being."

I would like to end this little talk with the word "friendship." "Life's friendships are given to us to cherish, as parts of God's plan for us." It seems to me that the Detroit Academy of Medicine has as one of its tenets—friendship. Speaking personally, I owe much to many members of our organization from the early days of practice to the present, not only for my patients, but for myself. The friendships of the Academy members are among those that I cherish most.

Guest Editorial

Cancer Patient Care

Adequate care of cancer patients is the goal of conscientious physicians. The aim of this issue has been to include articles dealing with several aspects of cancer patient management. These might be grouped into the somatic: surgical and radiation therapy, chemotherapy and supportive treatment; and what might be termed the psychic: the care of the patient's emotional and social reactions. Which of these two factors will be more important for any one patient may vary greatly and be quite impossible to predict at the onset of treatment. All physicians, then, must take both spheres into account.



Dr. Vandenberg

The somatic phase is primarily the concern of surgeon and radiation therapist, particularly when hope for cure exists. Local or systemic chemotherapy, used adjunctively, may assume a greater role in the cure of cancer. Before treatment is started consultation from radiation therapist, surgeon, internist and pathologist often is desirable. This type of cooperative planning is advocated by Gulick in his article on radiation therapy. It is hardly fair to expect every clinician to have unerring judgment. Consultation in problem cases is available to him in many hospitals from cancer committees or tumor boards. Much wider expansion of the number and activity of such boards of consultants is both possible and desirable. Such expansion is approved and encouraged by the Committee on Cancer of the American College of Surgeons, as Nelson implies in his article concerning tumor registries.

It seems appropriate that one article by a surgeon should be Saltzstein's report on the diagnosis of breast cancer since the principles of cancer surgery were first applied by Halsted to breast cancer.

Dr. Vaitkevicius's article on chemotherapy of advanced ovarian cancer illustrates the importance of chemotherapy. With the greatly increasing number of available drugs for cancer treatment a subspecialty of chemotherapy is evolving. Also available for palliative treatment and at times prolongation of life are radiation therapy, endocrine oblation, neurosurgery and other operations as well as a large number of nonspecific drugs.

Decisions about treatment for cure and palliation should take into consideration the patient's ability to adjust to deformity or alteration of important function, the reaction of the family, life expectancy, likelihood of return to work, availability of necessary care, financial status, expected relief from symptoms and risk of treatment.

The role of the physician in addition to that of scientist should be that of friend and counselor who supports the patient through whatever emotional reaction and social problems may arise. Ways of approaching this phase of patient care are given in Hirschfeld's article. Most patients accept their illness and adjust to it better when told its nature. They will be helped to adopt to their disease when communication lines with their families and physicians remain open.

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Implicit in the management of cancer patients is the recognition that adequate care can come about only when all appropriate forms of therapy are employed and each patient's personal needs are recognized and met.

HENRY J. VANDENBERG, JR., M.D.

Crisis Psychology

We have just passed through three hearings in Detroit, Grand Rapids and Lansing, on the Blue Cross-Blue Shield requests for rate adjustment held before the Insurance Comissioner.

The big headlines and front page stories of the Free Press remind us of earlier times. The medical profession opposed for many years the threat of national compulsory health insurance (Wagner-Murray-Dingell type bills) which had bothered us for 15 or 20 years. During that time the medical profession attained the reputation of always opposing legislation, never proposing. That era brought about the establishment of the Blue Cross-Blue Shield system of providing health care for our patients through the insurance principle—so that minimal but essential care could be provided from funds already accumulated.

This new type of group medical care grew out of a long period of depression and distress. During that time of national and financial distress we had a new President come into office. Distress continued to recurr. A new axiom appeared (quote from F.D.R.) "The only thing we have to fear is fear itself."

The nation, and also the medical profession, was in fear. When problems seemed to smooth out a little, another national emergency or calamity faced us: internationally, politically or in a socio-economic field which involved the medical profession. Numerous groups including labor, politicians, and unfortunately some of our own profession, opposed and obstructed progress of voluntary pre-payment plans for medical and hospital services. The Wagner-Murray-Dingell threat died off as a mass program and for a time conditions were better.

Lately, the same threat has recurred in the form of a "foot-in-the-door" Forand type bill, with support from great masses of labor, from numerous politicians, and from a few of our own profession.

Blue Cross and Blue Shield are now in the process of securing rate adjustments and the fear technique again has been invoked. To oppose this the medical profession is accused of mishandling the Blue Shield program, of being the cause of the increased costs and of improper administration. This complaint comes from two groups of people, the subscribers who complain about increased rates, and the older people who fear they will be priced out of the picture.

We have just been through a political campaign, a very large part of which emphasized the need of the over 65 people, and insistance that their medical and hospital care be placed under Social Security so that all of them would be eligible for health services.

This clamoring completely ignored the fact that over 70 per cent of the aged are able to provide for their own insurance and to pay their own bills. Almost half of the needy aged people are not under Social Security—never have been—but are under government care through regular tax channels.

The Blue Cross-Blue Shield request for rate adjustment does not include those in the special "Senior-Citizen" insurance program for the over 65 persons. No rate increases are contemplated for the "senior citizens," but they have been scared and have been swamping the hearings to complain on an item which does not affect them. This is a rate adjustment for retirees and those over 65 in group conversion (pay direct) program.

For the other groups, regular and M75 and its various modifications, the profession is accused of doing nothing to bring down costs. But the profession has. The average cost of services has been gradually reduced for the past five years from $36.36 to $30.65 in 1961. This means that Blue Shield and the medical profession have *reduced* costs in five years, not increased them.

What *has* produced the need for readjustment of rates comes from the subscribers—the beneficiaries—who have used the service. Those numbers have constantly increased in this same five years, from 26.70 in 1956 to 61.94 in 1960, per thousand subscribers. That is the item which is the major cause of trouble. The services from 1956 to 1960 increased over twice. Our actuaries and insurance advisors never anticipated that reaction. The adequacy and the solvency of Blue Shield is at stake. The rate readjustment requested would solve this present problem.

Professor Walter McNerney, who has been conducting the study growing out of the five-year-old Governor Williams Commission on the Blue Cross and Blue Shield, as yet has given us nothing tangible that we can use in the nature of figures, but told the Public Relations County Secretaries Conference in Lansing on January 29, that we have a wonderfully good program and are to be congratulated for having evolved a working voluntary prepayment program, but that we would lose our shirts unless practically every member of the Society supports it, watches out for abuses, makes the aging care work, no over charges, and the Insurance Commissioner grants the increase requested.

He says there are faults which can be corrected, but to date we have not had the benefit of his report. Professor McNerney told the Insurance Commissioner

at the hearing that the report might be published and ready "soon." That will again be entirely too late to help this immediate recurring problem. The report was too late two years ago when rate adjustments were heard. The report had been promised for not later than May 1959 at the outside. Originally, the promise had been for 1958, but the actual start of the study was delayed waiting for a sponsor and work schedule.

It was suggested at the recent Insurance Commissioner's hearing that very definitely another study of the Blue Shield program was demanded to solve these problems of administration and rates and adjustment, et cetera. Who would make that study? The University of Michigan has been doing this one for over four years. The American people have just been through a political campaign, lasting for many months, in which the people were told of our inadequate defense, of our inadequate nuclear fission program, of our inadequate inter-planetary space program, and of the inadequacy of medical and hospital care for the 16 million aging over 65.

Most of the medical profession knows and appreciates that the proposed care of the aging was not according to the facts. An acceptable and sufficient program has been enacted for these older people—the Kerr-Mills Bill.

Pressure and Fear Tactics Regenerated

The UAW recently held an anniversary meeting in Flint commemorating the famous forty-four day sit down strike against General Motors Corporation. Mr. Reuther is quoted to have said that the Union would not rest until Social Security benefits are not only increased for each worker, but also guaranteed to have his hospital and medical needs taken care of as part of his Social Security benefits. He indicated that medical care will be on the list of objectives in this year's contract negotiations.

On the "CBS Reports" program, February 9, Mr. Reuther debated with Edward R. Annis, M.D., of Miami, Florida. Mr. Reuther argued for President Kennedy's program of Health Care for the Aged through Social Security, and at every opportunity he criticized the American medical profession and the American Medical Association for, as he said, doing nothing to take care of the older people and of obstructing the program of national health insurance any way and always.

We wish to add our plaudits to Dr. Annis for his wonderfully efficient conduct and success, counter to probably the most experienced, aggressive and ruthless debator on the American scene. All comments we have heard have been most satisfying. Incidentally, our Michigan doctors will be interested to know that Dr. Annis was graduated from Annunciation High School in Detroit, also from the University of Detroit where he was an award-winner in debate. He received his medical education at Marquette.

As a means of fighting the various compulsory health plans of Wagner-Murray-Dingell, doctors in Michigan conducted studies in the 1920's and 1930's trying to demonstrate that private practice of medicine could evolve plans to avoid compulsory government plans. Appeals to the AMA headquarters officials demonstrated there was no economic information to establish an insurance principle. The insurance companies were also without data or actuarial information. After many years of effort, Michigan doctors and the Michigan State Medical Society established and proved medical care could be provided using the insurance principle.

The independent practitioners in hundreds of locations throughout the nation determined there must be a solution to this problem of paying for medical and hospital care, other than the old idea of pay if you can after the work is done, the doctor always being saddled with a collecting problem. In Michigan, Baylor University, Texas, California, and in the Northwest plans were established.

Luckily for the general public, as well as for the medical profession, dedicated men after many long studies succeeded in establishing the Blue Cross-Blue Shield principle, proving health care can be insured.

Mr. Reuther knows this. He also knows that for many years the AMA had had a complete change of heart, has recognized and requested Blue Shield plans to set up special programs whereby the older people can be provided health insurance. In his talk Mr. Reuther insisted that the 12 to 16 million persons in the old age group need health care. Blue Shield in Michigan has more than 60,000 over 65 persons now covered. Most of them were covered before they reached retirement age, others since, but none has ever been cancelled because of age. For the last four years, none have been denied the privilege of subscribing because of age. In his argument, Mr. Reuther claimed the care offered in these policies was inadequate.

Care Offered

The Kerr-Mills Act was passed by a resounding majority after both political parties had failed with their special programs. At first, the medical profession and the AMA were not satisfied, but certain changes were made, provisions set up and a working bill was secured.

It is now working in Michigan under governing local legislation.

The OASI beneficiaries and many others, Aid to Blind, etc., are acceptable under this program and through the State Department of Social Welfare, they can secure hospital and medical attention corresponding to that of Blue Cross and the Blue Shield. Such is the law in Michigan now.

Kennedy Old Age Plan

President Kennedy, on February 9, presented his medical care for the aged plan to Congress. He proposes that the O.A.S.I.* basic tax rate be increased from $4,800 to $5,000, and that the tax bite be increased ¼ of 1 per cent for the subscriber and for the employer. He offered, for everyone covered by social security or railroad retirement, a *compulsory insurance* setup to pay the greater part of hospital costs for people after they pass age 65. This insurance will pay hospital care above $10 a day for the first nine days of a hospital stay, then cover all costs thereafter up to a limit of 90 days for any single illness. This is definitely a deductible program that is proposed for those aged people whom he claims are financially unable to pay for insurance by themselves, such as Blue Cross-Blue Shield, et cetera. They must raise $90 to pay before the government takes over, then they are through unless they have another illness. Doctors and surgeons fees are not covered, but the insurance is to apply to as many different stays in the hospital as the patient needs after he is 65. Costs of diagnostic services at hospitals above $20 in any one instance also are to be covered by the proposed program.

Comments

If this plan should be enacted into law, the over 65 people and the public who will be compelled to take it will be disillusioned. They will have practically no insurance in place of what they are getting now. Seventy per cent are paying for voluntary health insurance.

Under the Kerr-Mills act the others who are needy will be covered, unless that act is rescinded. The danger of the Kennedy program is not that it will compete with private industry, if private industry is allowed to continue, but that by its very enactment, it sets a foot in the door through which the complsory health program will start.

Socialistic schemers have threatened for three decades at least to take over by merely extending age, or coverage, or time. The barrier will have been broached and the experience of the European nations will be ours also.

There is one other item which we should consider very thoroughly. For a long time the whole campaign has been one of fear tactics, scaring the old people especially, making them believe health services are denied them. That was the method of attack through the political campaign and has been followed since. We have had one political or social or economic crisis after another. This present situation reminds us very strongly of the days under FDR when as soon as one economic or international or political crisis was apparently quieted down, another would spring up.

The pressure from bureaucracy, calling attention to the supposed millions who cannot get medical care falls flat upon a busy practitioner who is now giving that care to these patients every day and who knows that no one need be neglected. There are plans and programs which will take care of them if they will but let someone know. The experience with the Insurance Commissioner and his hearings on the Blue Shield rate adjustment request is a case in point. Hundreds of old age people have swamped those hearings and protested. The fear of crisis, however, has caused them to panic. The medical profession is faced with a fight—a desperate fight—to preserve its independence. It has been through such fights before. In the far past the profession was accused of simply objecting and not proposing a remedy. That objection does not hold now. The profession has proposed many remedies. It developed the philosophy of pre-payment and has made it work; it has now developed a program applied to the over 65 people with low incomes and that is also working.

Many of our doctors and others have suggested that Blue Shield should sell deductible policies, claiming that would solve the problem. They forget that there is a deductible clause in the M 75 program and that out of 3½ million people covered, only 17,821 have accepted the deductible program. Michigan Medical Service knows deductible would be cheaper. Kennedy used that in his proposed program, but we also know that it has not sold to labor or to many others. In the automobile industry, deductible plans are used because the insurance companies have found it impossible to sell their increasingly expensive policies.

Editor's Note: The Michigan Medical Service Board, on March 1, authorized voluntary selection of deductible or full coverage to each subscriber in all plans offered.

House of Delegates

An emergency session of The MSMS Council on March 26 unanimously requested the speaker to call a special meeting of the MSMS House of Delegates, which was held April 16 at the Kellogg Center, Lansing, to consider and provide for social and economic threats to the profession.

*U. S. News and World Report, February 20.

Wayne Clinic Day Reunion Set May 3

Eight nationally-known experts in surgery, pathology and internal medicine will speak at the 93rd annual Clinic Day and Alumni Reunion of Wayne State University College of Medicine, Wednesday, May 3.

The event will be held at the Hotel Pick-Fort Shelby in Detroit.

The scientific program will be a memorial tribute to Drs. Osborne A. Brines, Charles G. Johnston and Gordon B. Myers. These men—all internationally-known educators and clinicians—died within a few weeks of each other in 1960. They were chiefs of the departments of pathology, surgery and internal medicine at the school and Receiving Hospital for many years.

Surgeons presenting papers will be: Champ Lyons, M.D., professor of surgery and chairman of the department, Medical College of Alabama; Rudolf J. Noer, M.D., professor and head, department of surgery, University of Louisville; Jonathan E. Rhoades, M.D., John Rhea Barton, Professor of Surgery, School of Medicine, University of Pennsylvania.

Pathology: Clyde Culbertson, M.D., Eli Lilly Company and E. R. Jennings, M.D., pathologist, Memorial Hospital, Long Beach, Calif.

Internal Medicine: Ovid O. Meyer, M.D., professor and chairman, department of medicine, University of Wisconsin medical school; Wesley W. Spink, M.D., professor of medicine, University of Minnesota Hospitals; Charles H. Brown, M.D., head, Department of Gastroenterology.

Health Council Conference To Feature Dr. Annis

Edward Annis, M.D., of Florida and a native of Michigan, will be the banquet speaker for the Michigan Health Council State Conference, May 23-25 at the Ballenger Fieldhouse of Flint Junior College. Doctor Annis will speak at the annual banquet on Wednesday, May 24.

The first day of the conference will be devoted to health careers. The main topics, scheduled for May 24, are community, school and rural health, and also health care of the aged. The Michigan Joint Council to Improve the Health Care of the Aged will conduct this part of the program.

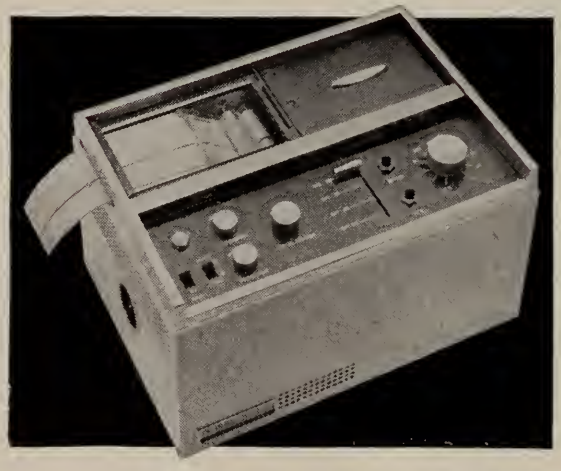
Emphasis May 25 will be on the Michigan State Medical Society's President's Program. Developed this year by MSMS, it seeks to add five good years of life to the people of the State through various health programs.

Harry A. Towsley, M.D., Ann Arbor, is general chairman of the conference.





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Hospital Accreditation Standards Revised; Changes Explained

The Board of the Joint Commission on Accreditation of Hospitals has adopted a revision of the Standards for Hospital Accreditation.

To be eligible for a survey for accreditation, the Commission requires that the hospital have at least twenty-five beds excluding bassinets, have been in operation for at least twelve months, and be accepted for listing by the American Hospital Association.

The listing requirements of the American Hospital Association were amended in 1959 and the Board of Commissioners voted on September 17, 1960, that for a hospital to be eligible for a survey for accreditation, it be listed by the American Hospital Association according to its listing requirements of 1959.

The significant changes in these requirements are:

"Only doctors of medicine or doctors of osteopathy shall practice in hospitals listed by the American Hospital Association. (This requirement is not intended to eliminate dental and similar services from the hospital. Patients admitted for such services, however, must have an admission history and physical examination done by a physician on the staff of the hospital, and a physician on the staff of the hospital shall be responsible for the patient's medical care throughout his stay.)

"The hospital shall submit evidence of regular care of the patient by the attending physician and of general supervision of the clinical work by doctors of medicine.

"If doctors of osteopathy are practicing in the hospital, then, under the requirements for listing, the overall supervision of clinical work must be under a doctor of medicine (as chief of staff and chief of department, if departmentalized). There is no intention to divorce the attending physician, either M.D. or D.O. from his patient, but the supervision of the clinical activities of all practitioners must be conducted by a doctor of medicine."

"Decision—A Moment of Truth" TV Show Started by MAP

"Decision—A Moment of Truth," a new televised series produced by the Michigan Association of the Professions and the Michigan Health Council, was initiated over WJBK-TV (Channel 2), Detroit, February 19.

The program theme concerns the decisions that professional men must make in the pursuit of their endeavors emphasizing that the decisions made by the professional people are the essence of their service to the public.

Say you saw it in the Journal of the Michigan State Medical Society

Prevent Overweight Through Better Eating Habits

Recipes and Menus with Satiety and Appetite Appeal in Mind

The Cook Book of Glorious Eating for Weight Watchers fills the long-felt need for a weight control plan that is workable for everybody in the family. Realistic regimens are built around good, natural, readily-available foods enhanced by delicious methods of preparation. In place of "fad diets" or tasteless formulas, it provides for truly appetizing meals. It teaches and encourages the development of the healthful eating habits that can prevent overweight, America's #1 Health Problem. This full-color cook book contains 100 pages—248 delicious recipes each with calorie counts. Complete menus are here at 3 calorie levels—1200, 1800, 2600. Calorie levels are related to *best* weights by sex, age, size and extent of activity.

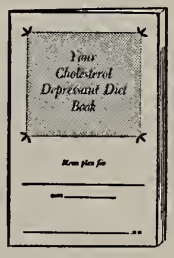
Many diets fail because they are crash programs only temporary in effect. Other diets are unbearable because they are monotonous and tasteless.

The Wesson way is not a crash program. It offers calorie controlled menus with appetite appeal, variety and satiety in mind. They fulfill the recommended dietary allowances of the Food & Nutrition Board of the National Research Council.

All menus provide the proper amount of protein, carbohydrates, fat and the other essential nutrients. The principles of good nutrition are included to help the homemaker plan her own properly balanced, calorie controlled menus. With simple subtractions or additions to the same basic menu, each family member can be served delicious satisfying menus according to his individual needs.

Not a reducing manual. It should be explained that "The Cook Book of Glorious Eating for Weight Watchers" is a guide to the *prevention of obesity*. Its publication marks the first time that a food manufacturer like Wesson has taken so important a step to help combat this serious public health problem.

Copies for physicians. "The Cook Book of Glorious Eating for Weight Watchers" is being offered to the general public. If you would like a copy for yourself, together with forms to enable patients to obtain their own copies, please fill in coupon below.



Note: *Please do not confuse this booklet with the Cholesterol Depressant Diet Book, published by Wesson as an aid to physicians and* for professional distribution only. *The concept of the Cholesterol Depressant Diet Book stems from Wesson's value in cholesterol depressant diets. Where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen, poly-unsaturated Wesson is unsurpassed by any readily available brand.*

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Pathology Comment

These items are provided by the Michigan Pathological Society

Phenylketonuria

Compared with other areas of medicine, progress in the treatment of mental deficiency has been very slow. But the physician can now offer hope in the prevention of certain forms of mental deficiency through the detection, prevention, and treatment of phenylketonuria.

Phenylketonuria is a metabolic disease that is the result of the body's being unable to utilize the essential amino acid, phenylalanine. This is a recessive hereditary malfunction that is compensated in utero by the mother. Phenylalanine begins to build up and reaches critical levels in the blood at about two weeks after birth. About the same time, the phenylketonuria develops in the urine, emitting the characteristic musty or "horse stable" odor that led to the detection of disease twenty-five years ago in a Norwegian child by Doctor Folling.

We now know that about one out of 70 people carry a recessive gene for this disease and about one out of every 20,000 children born have the disease. These facts indicate that all the siblings and cousins of known cases should be checked for the disease. Suspicion should be aroused by a family having other mentally deficient individuals and who have a very blond infant even blonder than his siblings, who may have an eczematous skin. Convulsions exist in 25 per cent of studied cases. The child usually exhibits, fairly early, the evidences of mental retardation and a bizarre type of behavior. The mental and behavior symptoms usually become more pronounced and less reversible with the age of the child.

Early detection of this disease is *most* important. A simple inexpensive test on the urine of every newborn at two to six weeks of age and at four months, six months, and one year of age, should be done as routine by every physician concerned with suspected children. The testing solution of ferric chloride can be dropped on the wet diaper; a commercially prepared testing stick can be applied to the wet diaper, or a sample of urine can be tested during the office visit. The test is read by observing the color of the testing drop or the solution when it comes in contact with the urine. Directions for these tests and a color chart may be obtained upon request from the Michigan Department of Health or Richard Allen, M.D., Director, Mental Study Unit, University of Michigan Medical Center, Ann Arbor. A diagnosis of PKU *should not* be made on a positive urine test alone. When a positive urine test is found, a sample of 6 ml. of whole blood is drawn under sterile conditions enough for 2 ml. of serum and sent to Doctor Allen's laboratory for evaluation. A serum phenylalanine level of 20 to 60 mg. per cent is a usual level of PKU patients while a normal serum has a level of 1 to 3 per cent phenylalanine. The blood serum should be kept cool or frozen and should be sent to the laboratory early in the week to avoid remaining in the mails any longer than necessary.

For the best service to the patient and to assist you, the physician, it is necessary to complete the record accompanying the serum. This information will enable the health department to give you more accurate evaluations, assist you in further casefinding of PKU. In view of the hereditary nature of PKU, the knowledge of recorded cases would furnish confirmatory data on all families and future cases.

The management and treatment is hinged on early diagnosis and must be adapted to the age of the patient. After the age of three years, little constructive improvement can be expected from present known regimen. The means of control and prevention of mental deficiency from PKU is that of a diet low in phenylalanine. This is accomplished in infants and small children mainly by special diet products available in the form of powders to be mixed with water. These products contain amino acids minus phenylalanine plus fat, carbohydrates, minerals, and vitamins. As the child develops, low protein food supplements, extra iron, and vitamins are added to the diet. Phenylalanine is an essential amino acid and must be provided for normal growth and development. This is provided from low protein foods in a supplement list. The diet must be continued through the growing years of the patient in order to prevent progress of the disease.

Prognosis: Long-term results of treatment are not available due to limited time this disease has been under study. The prevention of mental retardation and improvement of existing cases when found early or before the child reaches three years of age is without question. There is a definite change in the child's personality and behavior. There have been no definite

determinations on the length of time treatment should be continued. Indications and growth patterns of children would suggest continuing the treatment through childhood until further data is available.

In summary, phenylketonuria is a hereditary disease that can be detected early in infancy by a simple urine test and measurement of phenylalanine in the blood serum. When diagnosed, the disease can be managed by diet with the improvement and arrest of symptoms. Through detection of cases, valuable information relative to the families and their future children can serve to prevent further development of mentally deficient patients and a great savings of suffering and money to families and communities.

Laboratories to Discontinue Standard Kahn Test

The Division of Laboratories, Michigan Department of Health, will discontinue the performance of the Standard Kahn test for the serodiagnosis of syphilis on March 1, 1961. Effective this date, the routine test will be the VDRL slide test. The laboratories will continue to perform quantitative tests on all sera reactive to the VDRL test, and RPCF Tests on all reactive or weakly reactive sera.

The reports in the literature for the past few years and extensive preliminary testing in the Michigan Department of Health laboratories indicate that the VDRL test is slightly more specific in its reactivity and also slightly more sensitive. A decrease in the number of problems arising from premarital and prenatal serologic testing is anticipated.

The results of quantitative Kahn tests and quantitative VDRL tests are not strictly comparable. A number of the treated cases of syphilis may show a higher quantitative titer when tested by the VDRL method than had been previously found by the quantitative Kahn test. Such a rise should not necessarily be interpreted as a serologic relapse. In the absence of clinical symptoms of relapse the tests should be repeated in thirty to sixty days.

Psychiatric Hospital Costs

The average expenditure per day in 1958 for each patient in the nation's federal psychiatric hospitals was $10.61. In the voluntary psychiatric hospitals, the average expense per patient day was $16.35; in the proprietary psychiatric hospitals, $17.66; and in the state and local governmental psychiatric hospitals, $4.11. The expenses in all these hospitals are higher than in 1957.



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Dornwal is one tranquilizer that doesn't make people sleepy. It's a tranquilizer pure and simple. Its effectiveness you will see clearly the next time you encounter a patient given to tension headaches. Try Dornwal and see the results.

Dosage: One or two 200 mg. tablets three times a day. Children, age 6 to 16, one or two 100 mg. tablets two times a day. Administration limited to three months' duration.

Supplied: 200 mg. yellow scored tablets, and 100 mg. pink tablets, each in bottles of 100 and 500.

P.S. For the "Genericist", Dornwal is amphenidone

No absolute contraindications to the use of Dornwal are known. There have been no reports or evidence of habituation, addiction or drug tolerance in animal or clinical studies. Dornwal is relatively free from untoward effects when administered at recommended dosages.

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COMMUNICATIONS

Mr. William J. Burns,
Executive Director
Michigan State Medical Society
Dear Mr. Burns:

We want to thank you for your really generous cooperation in placing our AMEF ads in your journals and bulletins.

I do not believe there is a better way of promoting interest in contributing to medical education than to remind the physician frequently that the schools are in real need of financial help, and certainly one of the most effective methods is through your journals.

Again, both personally and on behalf of the Board of Directors, please let me thank you.

Sincerely yours,
JAY B. OLIVER, *Acting Director*
Chicago, Illinois *American Medical Education Foundation*

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Report to MSMS Council

The allegation in the newspapers that the White House Conference on Aging was "stacked" by the medical profession was entirely unfounded.

The facts of the matter are that of the some 2,700 delegates, less than 10 per cent were physicians. Most of the physicians were assigned to the section which considered health and medical care for the aged. When we arrived at the conference, we learned that this section was prohibited from considering the matter of financing of medical care and this matter was only to be considered by the section on Income Maintenance. The Income Maintenance section was unique for the fact that each of its work groups had as an officer someone from the field of social work and a representative of a labor union. There was only one physician among the officers of all of the work groups in that area.

It was clear to me that the Conference was not "stacked" by medicine and from the appearance of things, it is my opinion that there was reason to believe that there was a built-in bias in favor of federal support of medical care for the aged through the social security tax system.

I had anticipated that, by one means or another, the Conference would give an overwhelming approval to the social security approach to the medical care problem and therefore feel that the actual vote, being split to the point where a minority report from the Income Maintenance section was presented for the record, represents a token victory for medicine in its fight to protect the freedom of the American people.

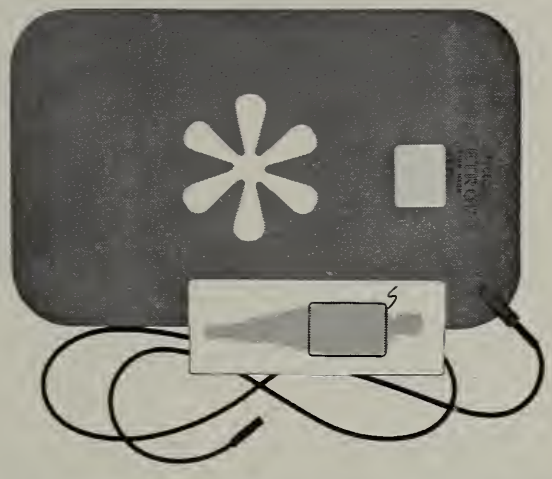
Although prohibited from doing so, the Health and Medical Care section did consider the question of financing medical care and there the vote was strongly against a social security type of financing but the report on this matter was not allowed to enter the record.

The Michigan State Medical Society arranged for a breakfast meeting of physician delegates to the Conference on the morning of the first day. This meeting was characterized by a sense of free exchange of information and was notable for the lack of any attempts at pressure or influence.

In my opinion, the Michigan State Medical Society approached the problems of the White House Conference on Aging with tact, intelligence and effectiveness.

C. J. TUPPER, M.D.
Assistant Dean
Ann Arbor, Michigan *University of Michigan*

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MARGARET SANGER RESEARCH BUREAU/**INTERIM REPORT**

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A. J. SOBRERO, M.D. *Research Director*

*PAT. NO. 2,943,979, OTHER PATS. PEND.

EDITORIAL OPINION

What Kind of Federal Help Do Our Old People Want?

Saturday Evening Post, March 11, 1961

People have been growing old for as long as the human race can remember—not quite as old as most of us expect to become, by the grace of God and antibiotics, but old nevertheless. But now there is a widespread feeling that "the aged" have become a class for whose welfare younger people feel free to prescribe. The things that young people think ought to interest old people are terrifying: Morris dancing, bingo, "discussion with others of the same age group," basket weaving and adult education. Few of the professionals give much thought to the odd-ball senior citizen who prefers to work as long as they'll let him, to participate in family and community activities without worrying too much about his great age.

This sort of thing aside, the gist of the problem of "our aging population" is financial. At the recent White House Conference on Aging, attention was concentrated on the sections which were assigned to discuss the cost of medical care and the best way to meet it. There was no need of a conference to make it clear that social workers, labor-union leaders, professors of social science and bureaucrats would tend to favor a Federal system of health insurance, whereas doctors, insurance executives, and economy-minded senators would be either against it or, at any rate, worried about it. And, of course, inasmuch as the Department of Health, Education and Welfare was putting on the show, it should have surprised nobody that the solution favored by HEW was the one favored by the conference. The surprise was that considerable opposition, criticism and reluctance cropped up.

Discussion of the financial problems of the aged, for example, was and is complicated by the variety of contradictory statistics presented on how the aged, sick or well, are doing as matters stand now. The Emory University survey, conducted under the direction of Professors Wiggins and Schoeck under a grant from the Foundation for Voluntary Welfare, indicated that a fair proportion of older people thought they were in good shape physically and weren't too much concerned over their ability to pay ordinary medical bills. On the other hand, George Meany, president of AFL-CIO, declared that three-fifths of our old people are "forced to get along on less than $1000 a year." Marion B. Folsom, former secretary of HEW, told his section that "retired people now get along fairly well with their income from private savings, company pension plans and Social Security, as evidenced by the fact that only 15 per cent of people over sixty-five receive Old Age Assistance, and the percentage is much lower in some industrial states." Mr. Folsom added, however, that, "a high percentage of older people do have difficulty in meeting the cost of medical care."

Aside from the increase in longevity, the high cost of housing and the greater activity of social workers, why has old age become so much more of a problem than it used to be? One answer was suggested at the White House Conference by Dr. Maurice E. Linden of the Philadelphia Department of Public Health. It was Doctor Linden's contention that the tendency to make old age a "problem" is a manifestation "of the same underlying disease—family, cultural and social fragmentation and breakdown. . . . Historically the problems of life occurred in the outside world and were solved within the family, but today it would appear that conflicts of living occur within the family and seek solution outside the family."

Thus what used to be intimate family problems become matters for the marriage counselor, the parole officer, the psychiatrist, the disciplinary school. Grandfather and grandmother, instead of enjoying an honored position in the home, become a problem for "social" solution. That children, as well as the state, have some responsibility for the care of their elders is generally ignored. Indeed, a brochure issued by HEW suggests that parents now live so long that they can no longer expect to remain "a part of their younger relatives' family." The idea of a statute of limitations on family loyalty is something new.

Just the same, even those who look to Federal bureaucracy to take care of our old people feel bad about it. Governor Meyner of New Jersey, for example, declared that "few of our senior citizens are crying, 'I am old, take care of me.' Rather I believe they are saying, 'Because of my age don't discriminate against me. Don't shut off employment opportunities.' "

Inflexible retirement plans were attacked by many delegates, although only Joseph Livingston, financial editor of the Philadelphia *Bulletin,* had the temerity to take the bull by the horns and urge the lifting of the earnings limitation for Social Security annuitants. The labor-union delegates, of whom there were 132, generally took the view that to do that would encourage the employment of old people at "substandard

wages"—that is to say, wages which, while presumably satisfactory to the recipient, might compete with union wage scales in certain sheltered trades. Nevertheless the growing idea that men and women are better off employed at something, as long as they are physically able to work, is an interesting shift from the earlier view that retirement was the be-all and end-all of a worker's life experience.

It can be argued that the Government itself, partly through its efforts to solve the problems of the needy, has contributed to the sorry plight in which some old people find themselves. For one thing, over the years Federal income tax has taken from our generation more than our fathers habitually saved. And, as Sen. Barry Goldwater of Arizona pointed out in an address at the conference, Government extravagance and deficit financing have created the inflation which cuts the buying power of pensions, Social Security annuities or other income available to old people.

Mr. Meany estimated that the twenty-two dollars a month, which was the average Social Secruity payment in 1940, would buy as much as forty-nine dollars would buy in 1959. Mr. Meany then proceeded to endorse "aid to education, assistance to distressed areas, loans and grants to communities for urban renewal and essential facilities and a broad housing program"— a set of recommendations which could easily reduce the purchasing power of the current average Social Security check of eighty-three dollars still further!

Inasmuch as it is admitted generally that indigence in old age by no means involves all old people, many question the good sense of firing a broadside at the whole aged population. The Kerr-Mills law now on the books attempts to confine the treatment to those who need it and to leave the administration of old-age medical care to the states, which are entitled to Federal grants if they adopt acceptable programs.

Few at the White House Conference thought favorably of the Kerr-Mills bill. The reason was that under it state authorities must establish the individual's need of aid before giving him any. To ask a man about to receive public money to show that he needs it is supposed to be an affront to his dignity and to make him a "second-class citizen." Old-age health insurance, like Social Security, it is insisted, should be a "matter of right" because the recipient has paid for it.

Obviously this is an emotional rather than a realistic view because, actuarially speaking, the Social Security annuitant hasn't paid for more than a fraction of what he gets. His employer had paid for half of it, and what does the boss get out of it "as a matter of right"? Perhaps he benefits by not having to provide such a generous pension system as he might otherwise be compelled to adopt, but that is another story. Even so, the financing of Social Security, being based



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on calculated payments to people as they reach a given age or to their survivors, is calculable and manageable. But health insurance is another story. An attempt to cover chronic illness, mental illness, senility, complicated surgery and the host of minor seizures and ailments to which aging flesh is heir could be financially disastrous. A limited coverage, designed to be supplemented by private health insurance and local hospital plans, would appear to be the optimum solution. The current agitation has shaken the insurance companies out of their complacency, and several promising private plans have been announced.

However, political pressures can be counted on to expand the coverage far beyond that contemplated at the beginning. If old people, why not youth, prospective mothers, delinquent children, alcoholics? It is this expansionist tendency that should be worrying advocates of a universal, compulsory health-insurance system.

Nation Needs Doctors

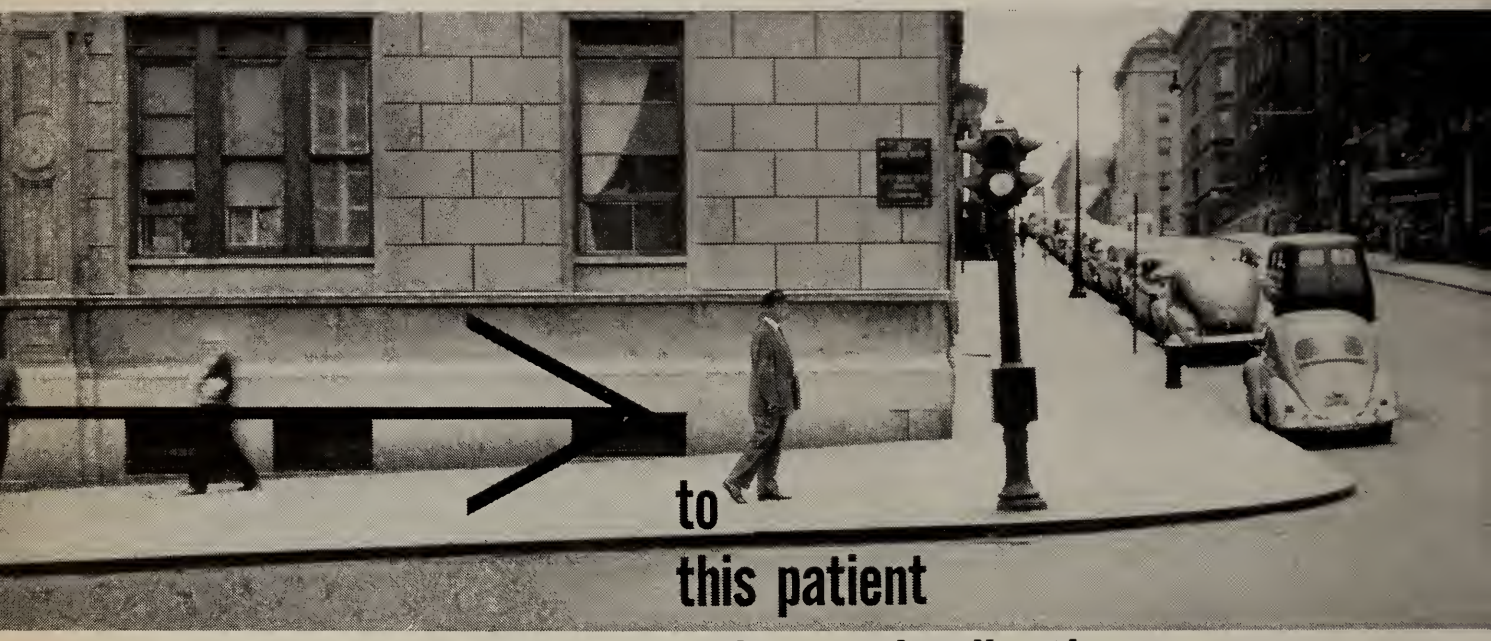
Ypsilanti Daily Press, January 2, 1961

Medicine today offers more opportunities and rewards than ever before. But the signs say that many young persons are failing to take advantage of them.

This unhappy piece of intelligence comes from the American Medical Association. The number of applicants for admission to the nation's 85 medical schools has been dropping. In 1947, for instance, nearly seven per cent of all college graduates made applications to these schools. In 1958, only four per cent did. There are known reasons why. The low birth rate of the '30's is one. Also multiplying opportunities in other professional fields are believed to be diverting possible medical candidates.

The pity of it is, as the AMA points out, that those who pass up medicine today are doing so at a time when it has become one of the most rapidly progressing fields of all, offering maximum promise for a young man or woman. In 1940, medical research amounted to $45 million—the 1960 figure was roughly $600 million, and predictions for 1970 go as high as $3 billion. The demand for medical researchers in the future will be matched only by the opportunities.

So far as the individual is concerned, the possible rewards are great, and the greatest by far is the doctor's capacity to do so much good for so many people. All of us should want to leave the world a little better place because we passed through it. The M.D. degree offers one big way of doing that.



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ANNUAL REPORT OF THE EDITOR

January, 1961

During the year 1960, THE JOURNAL of the Michigan State Medical Society completed Volume 59 and exactly 700 issues. We published the regular twelve issues of THE JOURNAL comprising 1912 pages, and three supplements: (1) Roster of Committee Personnel (8 pages). (2) The Proceedings of the House of Delegates (76 pages) and Annual Directory of Members (148 pages), making a grand total of 2144 pages. The first two supplements were part of the January number and the third was a supplement to the August number. This is a little smaller than the 1959 volume which had 2120 pages plus 112 pages of Directory. This difference in volume is accounted for by the cutting down in the number of pages in the last several numbers because of a decrease of advertising. So far, we have lost twelve to fourteen pages of advertising with each issue.

THE JOURNAL, in 1960, has continued its policy of publishing as many scientific articles as possible, also socio-economic material, society affairs and reports, committee work, and an editorial policy attempting to keep our members well informed of the actions of the Society, problems and the goals, plus allied information. During 1960, as mentioned, we published three supplements. For this coming year, we have made arrangements for two special numbers which will be published and mailed separately from THE JOURNAL. We believe this will avoid much of the delay in publication and will get the actual Journals out on time. This last year, The Proceedings supplement made the January number so big we had to break it into two parts—which produced considerable delay. The Directory number, which was part of the August issue, was not ready for mailing until three weeks after the August Journal was completed. Next year that will not happen. In 1960, we have had 202 authors listed in our contributors of original articles; nine of those appeared twice. A rather large percentage of our membership has contributed original articles to THE JOURNAL. Many others supplied committee reports, special reports, guest editorials, etc. We have published 58 editorials and 29 editorial comments. We have published 22 "Heartbeats," 16 legal opinions and 11 President's Pages.

Following the program of many years, each number of THE JOURNAL was devoted to some special interest of the medical profession or the Society, each with an appropriate cover. The January number was devoted to Congestive Heart Failure, with John G. Bielawski, M.D., and the Michigan Heart Association supplying most of the papers. February was devoted to Michigan Health Council and the Regional Health Conference of the AMA held in Grand Rapids. The March number was a memorial to L. Fernald Foster, M.D., Secretary to the State Medical Society for over 23 years and Honorary President-for-a-Day: his favorite portrait constituted the cover design.

April, as for many years, was devoted to Cancer with Gerald S. Wilson, M.D., of Detroit, acting as coordinator and assembling much of the material. We owe much of the material and ideas for the May issue on Geriatrics and Aging to the efforts of S. E. Chapin,



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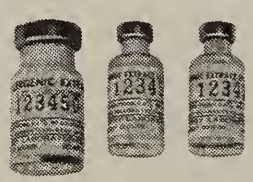
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M.D., of Dearborn; the cover depicted a Chinese symbol for longevity.

The June number for over a decade has been dedicated to Michigan Medical Service and this year we recognized its 20 years of service. G. Thomas McKean, M.D., and L. Gordon Goodrich helped to assemble this material. July announced the 1960 Annual Session and the cover was a photo of the 1959 House of Delegates in action.

The Kalamazoo Academy was honored in August with Robert D. Warnke, M.D., assembling the material for us; the cover depicted Kalamazoo's four hospitals and a picture of the famous business mall. The September Journal was dedicated to Better Mental Health Through Medical Team Work, with Raymond W. Waggoner, M.D., of University Hospital, Ann Arbor, coordinating this issue of THE JOURNAL. William L. Lowrie, M.D., and Fred W. Whitehouse, M.D., of Detroit, took charge of assembling the material for the Diabetes number in October. The cover memorialized the "greats" in diabetes from Aretaeus to Newburgh.

The Publication Committee had planned to use November 1960 for an introduction of our new MSMS Headquarters in Lansing but delays in construction upset those plans. Since the heart group for some time desired to switch their month from January to November, this was accomplished and Dr. Bielawski again assisted in collecting the material. For many years, December has been the announcement number for the Michigan Clinical Institute held in March, but that program was delayed, so we shifted it to January 1961 and pushed up the Child Welfare and Mental Retardation to the December number. Robert M. Heavenrich, M.D., of Saginaw, was helpful in selecting material for this issue which also memorialized the White House Conference on Youth.

THE JOURNALS for the year 1961 have all been assigned: Michigan Clinical Institute, Medical Writing, Rheumatism and Arthritis, Cancer Control, Dedication of the New MSMS Building, Michigan Medical Service, Annual Session, Ophthalmology, Otolaryngology, Aging, Heart, Calhoun County Medical Society.

THE JOURNAL, during the year 1960, completed its transformation and is materially different from its previous form. The new format, layout, and technical appearance have attracted the attention and compliments of many of our correspondents in other states. The Editor was invited and took part in the Conference of State Journal Editors in Lexington, Kentucky, where he participated in the program. He also attended the Annual Conference of the American Medical Writers Association in Chicago. It has been a challenge and a pleasure to work with the Publication Committee and with The Council in producing the 1960 volume of THE JOURNAL. We are proud and thankul in presenting it to you.

Respectfully submitted,
WILFRID HAUGHEY, M.D.
Editor

Addendum

The quality of any publication is the sum of many factors. These all ultimately resolve themselves back to the competence and acumen of the editor. Michigan has maintained over the years the outstanding State Medical Society Journal. The Publication Committee and Editorial Board take the occasion of the Editor's Annual Report to thank Wilfrid Haughey, M.D., in the name of the Society, for having acquired and maintained this distinction for Michigan medicine.

This addition to the Editor's Annual Report was approved by the MSMS Publications Committee and The Council at its January meeting.

Say you saw it in the Journal of the Michigan State Medical Society

BOOST STUDENT FUND

DeWITT T. BURTON, M.D., Detroit, was honored recently at a testimonial dinner honoring the Detroit physician for his contributions to medicine and education. Proceeds from the Cobo Hall dinner went to a scholarship fund for African students. Doctor Burton, who was instrumental in organizing the fund, is a member of the Wayne State University Board of Governors and has been a leader in several civic, medical and educational organizations.

* * *

RECEIVES CIVIC AWARD—Kenneth W. Carman, M.D., of Garden City, was selected as the "Outstanding Young Man for 1960" by the Garden City Junior Chamber of Commerce. Doctor Carman is a member of the Garden City Board of Education, the Mayor's Committee for Fluoride Treatment, and other community groups.

* * *

BOOK RELEASED—A book by John M. Dorsey, M.D., Detroit, has been published by the University of Virginia Press. The edition, "The Jefferson-Dunglison Letters" represent an exchange between President Jefferson and his physician Robley Dunglison, M.D. The chapter, entitled, "Jefferson, His Own Physician," is especially revealing.

* * *

U-M RANKS HIGH—A study by the Association of American Medical Colleges reveals that the University of Michigan ranks sixth in the nation in the number of graduates who are full-time teachers in U. S. medical schools. Ahead of the U-M were Harvard, Johns Hopkins, Pennsylvania, Columbia and the University of Chicago.

* * *

CITY COUNCIL MEMBER—Rene St. Louis, M.D., River Rouge, has been appointed to the River Rouge City Council.

* * *

LEADS CHICAGO MEETING—Ralph S. Green, M.D., Rochester, was program chairman for the recent annual meeting of the Central Neuropsychiatric Hospital Association in Chicago. He also serves as secretary-treasurer of the Association.

* * *

STEP UP U-M SCHEDULE—The University of Michigan Medical School has adopted a 12-month schedule for junior medical students, and modified the curriculum for juniors and seniors. Dean William N. Hubbard, Jr., M.D., explains that immediately following the sophomore year, a student will begin serving as an active member of a health team under the close supervision of faculty physicians. His clinical instruction will be oriented about the welfare of the individual patient, and formal lectures will be reduced to one hour a day. Students will spend 60 to 90 days in each field of clinical medicine.



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IMPORTANT PANEL—John S. DeTar, M.D., Milan, former president of the American Academy of General Practice, will moderate an important panel at the AAGP assembly at Miami Beach April 17-20. The panel on "Economics of Medicine—Today and Tomorrow" will include Walter Reuther, E. Vincent Askey, M.D., and others.

* * *

HEAR AUTHOR—Alfred H. Stanton, M.D., Waverley, Massachusetts, author of "The Mental Hospital," presented a paper on "The Acting Out Patient" in Detroit March 11. He was the seventh speaker in a series sponsored by The Haven Sanitarium, Rochester.

* * *

VISITS JAPAN—Thomas Francis, Jr., Ann Arbor, has been in Japan for the National Academy of Sciences and the National Research Council to consult with the staff of the Atomic Bomb Casualty Commission.

* * *

TO FINANCE BOOK—The McGregor Fund, Detroit, has provided a $10,000 grant to Wayne State University Press to subsidize the publication of "Occupational Health in America." The authors are Alfred H. Whittaker, M.D., and Henry B. Selleck, also of Detroit.

* * *

HONORED—E. C. Swanson, M.D., Vassar, Secretary to the Michigan State Board of Registration in Medicine, was elected recently as Vice President of the Federation of Medical Boards of the United States of America, at its annual meeting in Chicago.

* * *

HEAD SKI GROUP—Three Sault Ste. Marie doctors of medicine were elected officers at the recent formation meeting of the Canadian-American Medical Ski Association at Mission Hill. H. R. Allott, M.D., was elected president; D. D. Finlayson, M.D., vice president, and Tony J. Trapasso, M.D., secretary-treasurer.

* * *

NEW U-M CHAIRMAN—Walter P. Work, M.D., of the University of California School of Medicine, San Francisco, has been named chairman of the Department of Otolaryngology at The University of Michigan Medical School. The appointment will bring Dr. Work back to the University after a 20-year absence.

As chairman, Dr. Work will succeed the late James H. Maxwell, M.D. A. C. Furstenberg, M.D., dean emeritus of the Medical School, has been serving as acting chairman.

* * *

OFFER GRAD ASSISTANTSHIPS—Graduate assistantships for masters and doctoral students in microbiology will be offered at Wayne State University's College of Medicine beginning in September.

The stipend for graduate assistantships ranges from $2,000 to $3,000 for 12 months with tuition paid.

For applications and information write Department of Microbiology, Wayne State University, College of Medicine, 1401 Rivard, Detroit 7.

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PLACEMENTS—M.D. locations in Michigan in December, January and February as recorded by the Michigan Health Council:

Placed by Michigan Health Council—Marcus B. Sheffer, M.D., in Owosso, and Luke Sheng, M.D., in Brighton.

Assisted by Michigan Health Council—James A. Kiley, M.D., Manistee; Maurice H. Chapin, M.D., Millington; Alfred E. Neuffer, M.D., Mt. Pleasant, and L. A. Ginnebaugh, M.D., Fort Custer (State Home & Training School).

MEDICAL MEETINGS USA

Muskegon Committee on Trauma, (Michigan Regional Meeting, American College of Surgeons), April 12, Hackley Memorial Hospital—Emil J. Lauretti, M.D., Chairman.

American Academy of General Practice, April 13-20, 1961, Miami Beach, Fla. Mac F. Cahal, Volker Blvd. at Brookside, Kansas City 12, Mo., Executive Director.

Fifth Post-Graduate Course on Fractures and Other Trauma sponsored by the Chicago Committee on Trauma of the American College of Surgeons, April 19-22, 1961, John B. Murphy Memorial Auditorium, 50 East Erie Street, Chicago.

American College of Obstetricians and Gynecologists, April 21-28, 1961, Americana Hotel, Miami Beach, Fla. Donald F. Richardson, 79 W. Monroe St., Chicago 3, Ill., Executive Secretary.

Thirty-Second Annual Meeting of Aerospace Medical Association, April 24-26, 1961, Chicago. Willion J. Kennard, M.D., c/o Washington National Airport, Washington, D. C., Secretary-Treasurer.

American Association for Thoracic Surgery, April 24-26, 1961, Sheraton Hotel, Philadelphia, Pa. Hiram T. Langston, M.D., 308 Carondelet Bldg., 7730 Carondelet Ave., St. Louis 5, Secretary.

American Pediatric Society, May 2-3, 1961, Hotel Traymore, Atlantic City, Conrad M. Riley, Denver General Hospital, Denver 4, Secretary.

Student American Medical Association, Congress, May 3-7, 1961, Chicago. Russell F. Staudacher, 430 N. Michigan Ave., Chicago 11, Executive Director.

Symposium on Hypertension, Hahnemann Medical College, May 4-7, 1961, Philadelphia, Pa. Consult Albert N. Brest, M.D., 230 North Broad.

American Society of Internal Medicine, May 5-7, 1961, Eden Roc Hotel, Miami Beach, Fla. G. Tod Bates, 350 Post St., San Francisco 8, Executive Director.

American College of Physicians, May 8-12, 1961, Americana Hotel, Miami Beach, Fla. Edward C. Rosenow, Jr., M.D., 4200 Pine St., Philadelphia 4, Executive Director.

American Psychiatric Association, May 8-12, 1961, Morrison Hotel, Chicago. C. H. Hardin Branch, M.D., 156 Westminster Ave., Salt Lake City 15, Utah, Secretary.

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International College of Surgeons, North American Federation Congress, May 15-18, 1961, Palmer House, Chicago. Horace E. Turner, M.D., 1516 Lake Shore Drive, Chicago, Secretary General.

American College of Cardiology, Inc., May 16-20, 1961, Biltmore Hotel, Philip Reichert, M.D., 350 Fifth Ave., Empire State Bldg., New York 1, Executive Director.

American Association of Plastic Surgeons (members and guests), May 17-19, 1961, Commodore Hotel, New York City. Thomas D. Cronin, M.D., 6615 Travis St., Houston 25, Texas, Executive Secretary.

American Orthopaedic Association (members and guests), May 22-25, 1961, The Ahwahnee, Yosemite, Calif., Lee Ramsay Straub, M.D., 535 E. 70th St., New York 21, Secretary.

American Urological Association, Inc., May 22-25, 1961, Biltmore Hotel, Los Angeles. William P. Didusch, 1120 N. Charles St., Baltimore 1, Executive Secretary.

National Tuberculosis Association, May 22-25, 1961, Netherland-Hilton, Cincinnati. James G. Stone, 1790 Broadway, New York 19, Executive Secretary.

American Otological Society, Inc., May 26-27, 1961, Lake Placid Club, Essex County, N. Y. James A. Moore, M.D., 525 E. 68th St., New York 21, Secretary-Treasurer.

American Gynecological Society, May 29-31, 1961, The Broadmoor, Colorado Springs, Colo. Albert H. Aldridge, M.D., 899 Park Ave., New York 21, President.

American Neurological Association, June 12-14, 1961, Hotel Claridge, Atlantic City. Melvin D. Yahr, M.D., Neurological Institute, 710 W. 168th St., New York 32, Executive Secretary.

American Dermatological Association, Inc. (members only), June 16-20, 1961, Castle Harbour Hotel, Tucker's Town, Bermuda. Wiley M. Sams, M.D., 25 S.E. Second Ave., Miami 32, Fla., Secretary.

American Proctologic Society, June 21-24, 1961, Pittsburgh Hilton Hotel, Pittsburgh. Norman D. Nigro, M.D., 10 Peterboro St., Detroit, Secretary.

American Rheumatism Association, June 22-23, 1961, Hotel Roosevelt, New York City. Gerard W. Speyer, 10 Columbus Circle, New York 19, Executive Secretary.

American Geriatrics Society, June 22-23, 1961, New York City. Richard J. Kraemer, M.D., 2907 Post Rd., Greenwood, Warwick, R. I.

American College of Chest Physicians, June 22-26, 1961, Hotel Commodore, New York City. Murray Kornfeld, 112 E. Chestnut St., Chicago, Executive Director.

American Diabetes Association, Inc., June 24-25, 1961, Commodore Hotel, New York City. J. Richard Connelly, M.D., 1 E. 45th St., New York 17, Executive Secretary.

American Medical Association Annual Meeting, June 25-30, 1961, New York City.

DON'T FORGET

The Annual Meeting of the AMERICAN MEDICAL ASSOCIATION, The Coliseum, New York, June 25-30, 1961.

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Michigan Authors

Melvin L. Selzer, M.D., Ann Arbor, "Automobile Accidents and the Alcoholic Personality: An Unrecognized Dilemma," *Michigan State Bar Journal,* November, 1960.

Marcus H. Sugarman, M.D., Oscar Bigman, M.D., and **Thadeus L. Jarkowski, M.D.,** Detroit, "Whipple's Disease, Report of a Case in a Negro Woman Diagnosed by Transoral Jejunal Biopsy," *Journal American Medical Association,* December 31, 1960.

Milton W. White, M.D., Waldemar Palutke, B.S., and **James M. Orten, Ph.D.,** Detroit, "Tissue Factors and Resistance to Carcinoma," *The Journal of the International College of Surgeons,* January, 1961.

Harry C. Saltzstein, M.D., Detroit, "Comments on the Fourth (1960) National Cancer Conference," *Harper Hospital Bulletin,* November-December, 1960.

R. E. Reinhard, M.D., and **A. R. W. Climie, M.D.,** Detroit, "Testicular Tumors—The Harper Hospital Experience, 1947-1959," *Harper Hospital Bulletin,* November-December, 1960.

Harold M. Frost, M.D., Detroit, "Crossed-Pin Technique in Management of Complex Tibial Fractures" and "Introduction to Joint Biomechanics," *Henry Ford Hospital Medical Bulletin,* December, 1960.

John H. Wylie, Jr., M.D., Detroit, "Acute Cholecystitis in Children," *Henry Ford Hospital Medical Bulletin,* December, 1960.

J. H. Shaffer, M.D., L. L. Diiella, M.D., and **J. A. Marvel, M.D.,** Detroit, "Bronchial Asthma in Adults," *Journal American Medical Association,* December 3, 1960.

J. K. Ormond, M.D., Pontiac, "Idiopathic Retroperitoneal Fibrosis," *Journal American Medical Association,* November 19, 1960.

Robert Rapp, M.D., John G. Weeks, M.D., and **Robert E. Hodges, M.D.,** Ann Arbor, "Renal Artery Opacification During Intravenous Pyelography," *University of Michigan Medical Bulletin,* September, 1960.

William J. Mersch, M.D., and **Melvin A. Block, M.D.,** Detroit, "Intussusception Following Intestinal Intubation," *Archives of Surgery,* December, 1960.

Samuel J. Levin, M.D., Detroit, "Hyposensitization—Seasonal Rhinitis," *Connecticut Medicine,* December, 1960.

R. V. August, M.D., Muskegon Heights, "Hallucinatory Experiences Utilized for Obstetric Hypoanesthesia," *American Journal of Clinical Hypnosis,* October, 1960.

George J. Curry, M.D., Flint, "Responsibility to the Injured," *Journal Medical Association of Georgia,* January, 1961.

Martin Feldstein, M.D., Detroit, "Ocular Surgery in the Aged," *Clinical Medicine,* January, 1961.

Albert J. Macksood, M.D., Roger F. Smith, M.D., Richard B. Marshall, M.D., and **Robert C. Horn, M.D.,** Detroit, "Warthin's Tumor of the Parotid Gland," *Henry Ford Hospital Medical Bulletin,* December, 1960.

Thomas Gahagan, M.D., Detroit, "The Trendelenburg Operation: Pulmonary Artery Embolectomy," *Henry Ford Hospital Medical Bulletin,* December, 1960.

Alex P. Kelly, Jr., M.D., Detroit, "The Injection of Noxious Materials into the Hand," *Henry Ford Hospital Medical Bulletin,* December, 1960.

Roger F. Smith, M.D., and **D. Emerick Szilagyi, M.D.,** Detroit, "Healing Complications with Plastic Arterial Implants," *Archives of Surgery,* January, 1961.

Seward E. Miller, M.D., Ann Arbor, "New Concepts of Industrial Dust Diseases," *Industrial Medicine and Surgery,* January, 1961.

K. R. Magee, M.D., and **R. D. DeJong, M.D.,** Ann Arbor, "Paralytic Brachial Neuritis," *Journal American Medical Association,* November 5, 1960.

George D. Zuidema, M.D., Ann Arbor, "Surgical Management of Superior Mesenteric Arterial Emboli," *Archives of Surgery,* February, 1961.

Joseph Beninson, M.D., and **Dwight C. Ensign, M.D.,** Detroit, "Leg Ulcers in Rheumatoid Arthritis," *Journal American Medical Association,* February 11, 1961.

Leonard F. Bender, M.D., and **James W. Rae, Jr., M.D.,** Ann Arbor, "Modified Shoulder Saddle Harness for Upper Extremity Prostheses," *Archives of Physical Medicine and Rehabilitation,* February, 1961.

J. Edward Berk, M.D., Detroit, "Some Critical Thoughts on the Evaluation of Antacids in the Treatment of Peptic Ulcer," *Current Therapeutic Research,* February, 1961.

H. U. Waggener, M.D., Denver, and **James A. Ferguson, M.D.,** Grand Rapids, "Total Colonoscopy and Polyps of the Colon," *Rocky Mountain Medical Journal,* February, 1961.

Mary E. Clifford, M.D., and **Park W. Willis, III, M.D.,** Ann Arbor, "Sound in Cardiac Diagnosis," *University of Michigan Medical Bulletin,* November, 1960.

Frank Whitehouse, Jr., M.D., Arthur G. Johnson, Ph.D., and **Leighton N. L. Kong,** Med. '61, "Increased Survival of Mice Challenged with Ehrlich Ascites Tumor Following Immunization with Tumor plus Endotoxin," *University of Michigan Medical Bulletin,* November, 1960.

IN MEMORIAM

PHILIP D. BOURLAND, M.D., eighty-seven, Calumet physician, died January 30, 1961.

Doctor Bourland was born in Peoria, Illinois, and was graduated from Peoria High School. He was graduated from the University of Michigan in 1895 with a degree in chemistry and worked as an analytical chemist before returning to the University of Michigan to study medicine. He received his M.D. degree there in 1899.

Following internship at Calumet in 1899, he practiced in Lake Linden until 1922, when he was transferred to Calumet as chief of the medical staff for the Calumet and Hecla Mining Company. He held that position until his retirement in 1946.

Doctor Bourland was a life member of the Michigan State Medical Society.

FRANK V. CARNEY, M.D., seventy-five, St. Clair physician and mayor, died January 20, 1961.

Doctor Carney was serving his fifteenth term as mayor of St. Clair.

He was a long-time member of the State Bridge Commission, and a member of the St. Clair County Coordinating Zoning Commission. He also served 10 years as a St. Clair city councilman, 24 years as a school board member, and five years as a member of the County Board of Supervisors. He was on the staffs of St. Clair Community Hospital, Port Huron Hospital and Mercy Hospital, Port Huron.

RALPH G. FERRIS, M.D., sixty-seven, Birmingham physician, died January 29, 1961.

Doctor Ferris was a Navy lieutenant in World War I and was graduated from the Detroit College of Medicine and Surgery. He started his practice as an eye, ear and throat doctor in Birmingham in 1925.

JAMES C. GIBSON, M.D., ninety-one, retired Milford physician, died February 15, 1961.

Doctor Gibson received his doctor of medicine degree from Queen's University Faculty of Medicine, Kingston, Ontario, in 1892, and was licensed to practice medicine in Michigan in 1900.

He was a life member of the Michigan State Medical Society.

JEROME T. JEROME, M.D., sixty-one, nationally-known orthopedic surgeon of Traverse City, died January 30, 1961.

Born in Detroit, Doctor Jerome attended Hillsdale College and the University of Michigan, receiving his M.D. from the U-M. He served his internship at University Hospital, Ann Arbor, and later attended the University of Chicago where he received specialized training in orthopedic surgery. He was resident in orthopedic surgery at Herman Kiefer Hospital, Detroit, for one year, after which he was associated with the Jackson Clinic in Madison, Wisconsin, for three years. He established practice in Traverse City in 1938.

Doctor Jerome was a member of the American College of Surgeons, Clinical Orthopedic Society, and a diplomate of the American Board of Orthopedic Surgery.

MICHAEL R. MURPHY, M.D., fifty-six, Cadillac practitioner since 1932, died February 14, 1961.

Born at Marshall, Indiana, Doctor Murphy later moved to Grand Rapids, graduating from Catholic Central High School. He attended Loyola University at Chicago and did his graduate work at the University of Pennsylvania and the University of Michigan. He was accepted for fellowship in the American College of Surgeons in 1948. He served as a captain in the Medical Corps during World War II after receiving his commission in the reserve corps in 1934. In 1955 he served as president of the Public Health and Anti-Tuberculosis Society.

He was named to the MSMS House of Delegates in 1950.

EARLE E. SCHUMACHER, JR., M.D., thirty-five, Grand Rapids internist and cardiologist, died February 7, 1961.

A native of Maplewood, N. J., Doctor Schumacher gradu-

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ated from the University of Michigan Medical School in 1949. He practiced at Detroit and Chicago before moving to Grand Rapids eight years ago. He was on the staff of Butterworth Hospital there. He was a Fellow of the American College of Internists.



ROGER V. WALKER

ROGER V. WALKER, M.D., sixty-five, longtime member of the MSMS legal affairs committee and prominent surgeon and Detroit Board of Health Commissioner, died February 24 in Detroit.

A native of Detroit, he was graduated from the University of Michigan and the Wayne University College of Medicine in 1919. He began his practice in Detroit that year. He served as a lieutenant in the Army Medical Corps during World War I.

Former professor of clinical surgery at WSU College of Medicine, Doctor Walker was chief of staff at Providence Hospital, was chief of staff of Wayne County General Hospital and was president of the Detroit Board of Health. At the time of his death, he was an attending surgeon at Detroit Memorial Hospital and consultant in surgery at Wayne General.

Active in many medical organizations, he was secretary of the Academy of Surgery of Detroit from 1929 to 1944 and president in 1945 and 1946.

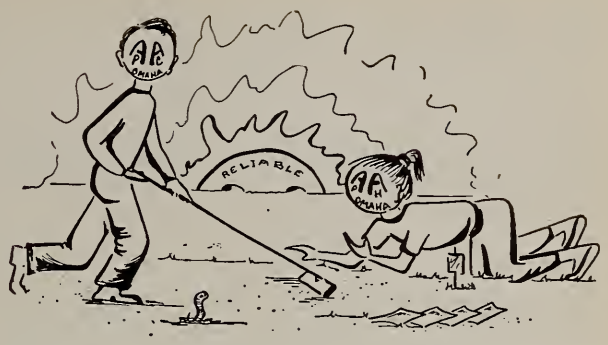
DOUGLAS J. WATSON, M.D., forty-eight, Detroit surgeon for 22 years, died February 10, 1961.

Doctor Watson was on the staffs of Mt. Carmel and Oakwood Hospitals and was a member of the Detroit Surgical Society.

Next MSMS Directory to be Published in '62

As an economy measure, The MSMS Council has decided that the Directory of MSMS Members should be published every second year, rather than annually.

The last MSMS Directory was distributed to members in August, 1960, and the next will be published in 1962. Supplementary lists are planned for interval publication in JMSMS to provide names of NEW members.



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The Doctor's Library

Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

SYNOPSIS OF PATHOLOGY. By W. A. D. Anderson, M.A., M.D., F.A.C.P., F.C.A.P., Professor of Pathology, University of Miami School of Medicine; Director of Pathology Laboratories, Jackson Memorial Hospital, Miami, Florida. 414 text illustrations and 4 color plates. Fifth edition. St. Louis: C. V. Mosby Company, 1960. Price, $9.25.

This is the fifth edition of this popular, concise, comprehensive review of pathology. Again, the accent remains on condensation and a basic presentation of the subject minus the myriad of detail exacted of the larger standard texts. All chapters have been subjected to revision. However, the changing pattern of disease has necessitated new accent on oncology, newly recognized diseases and syndromes, recent significant research achievements and a new perspective on the hypersensitivity diseases.

This, of course, is no replacement for the larger classical texts. However, as a useful, ready reference for the practicing physician, it is exceedingly beneficial.

J.G.G.

JEFFERSON-DUNGLISON CORRESPONDENCE. By John Dorsey. Charlottesville, Va.: University of Virginia Press, 1960. Price, $5.00.

Lovers of books, lovers of unusual and intriguing history will be most happy with John M. Dorsey's book. Thomas Jefferson wrote letters of various import to his physician at a time when he was director of the University of Virginia then being established. It describes travails, the problems, the frustrations in getting together materials and teachers to establish a medical school in Charlottesville, Virginia.

The long process included buying books and laboratory materials including skeletons for the use of the students. He also describes his own symptoms and consults his physician by mail as well as personally. The doctor visiting him at his house, and the doctor's letters of reply are enclosed. It is a most interesting book that one cannot lay down until he finishes it. We congratulate Doctor Dorsey on a wonderful job.

GENERAL ANESTHESIA. Edited by Frankis T. Evans, M.B., B.S., F.F.A.R.C.S., D.A., Anesthetist, St. Bartholomew's Hospital, St. Mark's Hospital for Rectal Disease, and Royal Masonic Hospital, London and Cecil Gray, M.D., F.F.A.R.C.S., D.A., Professor of Anesthesia, University of Liverpool. Volume I, Basic Principles; Volume 2, Techniques, Special Fields and Hazards. London: Butterworth & Co. (Publishers) Ltd., 1959.

This is a textbook of anesthesia in two volumes, designed for use by postgraduate students whose study in the past has been confined, of necessity, to a series of excellent monographs. Volume I concerns itself with the advanced basic anatomy and physiology of the cardiorespiratory system as well as to the pharmacology of volatile, gaseous and intravenous anesthetics. In addition, a thorough consideration of pre-anesthetic medication, the muscular relaxants, blood transfusion and fluid therapy are viewed.

Volume II deals with special anesthetic problems in the various surgical sub-specialties. The principles in management of anesthesia in the face of concurrent medical disease are also treated.

The books are clearly illustrated, cogent, concise and easily read; certainly, an essential reference text for those who bear responsibility in anesthesic administration.

J.G.G.

CARDIAC EMERGENCIES AND RELATED DISORDERS. Their Mechanism, Recognition and Management. By Harold D. Levine, M.D., Senior Associate in Medicine, Peter Bent Brigham Hospital, Boston, Mass.; Assistant Clinical Professor of Medicine, Harvard Medical School. New York: Landsberger Medical Books, Inc., 1960. Price, $12.00.

This is an excellent monograph on the subject of Cardiac Emergencies presenting practical, detailed discussions of their management and clinical recognition in an easily assimilable form. As the Preface states, it represents an outgrowth of a series of seminars given to fourth-year Harvard students, over a period of the last fifteen years, at the Peter Bent Brigham Hospital.

This is a small, compact volume, well indexed and clearly printed on good stock. Adequate illustrations are provided. It is of value not only to the medical specialist, the cardiologist, but to every practitioner of medicine, and should be almost as handy to each one as his stethoscope.

R.W.B.

PARDON MY SNEEZE. The Story of Allergy. By Milton Millman, M.D., Fellow, American College of Allergists; Member, American Academy of Allergy; Past President, San Diego Biomedical Research Institute. 216 pages. Price $4.00.

Doctor Millman gives all the theories and problems of allergy in all of its stages with descriptions, complaints and immense amount of useful material in the form of diets. Special diets are recommended for various allergies and for people who are allergic to special foods, with suggestions on how to substitute for them.

The book, which is pocket size with a stiff pasteboard cover, is well printed and well constructed with large type which can be easily read.

We enjoyed reading the book. It will be very handy for allergic patients and their families.

MEDICAL HISTORY TAKING. By Ian Stevenson, M.D., Professor of Psychiatry and Chairman, Department of Neurology and Psychiatry, University of Virginia School of Medicine. New York: Paul B. Hoeber, Inc., Medical Division of Harper & Brothers, 1960. Price, $6.50.

Certainly, no one can deny the importance of a proper history in the daily practice of medicine. It is true that most texts on physical diagnosis deal only briefly with history-taking and the art of interviewing a patient. This

book attempts to promote efficiency in the techniques of the medical interview and should prove to be useful to medical students, primarily, but also to practitioners, who would like to improve their ability in this important part of their daily work.

The physician-patient relationship is discussed, attitudes are stressed, and the importance of suiting one's language to the patient's comprehension is emphasized. Following a discussion of the procedures and processes of the medical interview, the history of the present illness is taken up in detail, and special questions about common symptoms which should be elicited, should be discussed. The patient's attitude toward his illness is considered of importance in eliciting the history. The family, personal and past history, are discussed, in that order. The importance of providing directions or topics of significance is discussed and suggestions are offered on the techniques to be utilized. Such are important particularly in the psychological and emotional fields. Techniques of helping patients to talk freely are discussed, as well as how to guide an interview.

The reviewer believes the book contains many helpful suggestions in the art of history taking, and should be valuable to the medical student if he has time to delve into the subject to this degree. It is an excellent guide for instruction in this important subject.

R.W.B.

WHAT PRICE MEDICAL CARE? A Preventive Prescription for Private Medicine. By the author of The Australian National Health Plan, a former Prime Minister and Minister for Health of Australia—Doctor the Rt. Hon. Sir Earle Page, G.C.M.G., C.H., M.B., CH.M., F.R.A.C.S., F.R.C.S. (HON.), D.SC. (HON.), M.P., Chancellor of University of New England. With Introduction by E. A. Van Steenwyk. J. B. Lippincott Company. Philadelphia and New York. Price $3.50.

Sir Earle Page, the author of this book, was at the head of the medical program in Australia and at one time was Prime Minister of Australia. The Australian medical care program bears his name. He has been intimately associated with medical practice for more than sixty years, running hospitals, establishing a hospital, being a surgeon for many years, active in governmental work in the administration of health services and familiar with the problems which the doctors of Australia have. He served in the first World War, visited the Mayos on his way back home. In Australia, friendly societies and numerous insurance plans have been in effect for more than 100 years. During his administrative period as health commissioner, some other schemes, as they were called, were worked out. A program was developed in Australia which he fairly well describes.

This program is a partially governmental program, the government paying certain definite amounts for indicated services, the insurance plan paying a certain amount, and the doctor charging the family more if he deems it necessary. This had to be done to avoid complete socialized medicine. The present program started in about 1951. Doctor Page made several trips to America, and he invited two of the American administrators to Australia, Wm. McNary of Michigan Hospital Service and E. A. Van Steenwyk of the Philadelphia Plan. He mentions the American plans in many places throughout the book—mostly Blue Cross, but frequently Blue Shield—gives reasons for high medical costs and proper excuses for them. He devotes a chapter to abuses and misuses, "avoiding an incubus," and has a chapter on "Prevention Pays Big Dividends." The Australian plan requires a physical examination twice a year as a preventive measure and he claims it pays well. We were very much intrigued with this book and believe that many of our leaders in medicine in America could profit very well by reading it. Sir Earle Page believes that he has the answer for many of our American problems and is willing to give them to us in exchange for the much that American medicine has taught him. There are no new suggestions. We have heard them all in our Michigan programs, but coming from a different angle and put in different words, they are worthy of consideration.

CELLULAR ASPECTS OF IMMUNITY, CIBA FOUNDATION SYMPOSIUM. Editors for the Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Maeve O'Connor, H.A. 177 illustrations. Boston: Little, Brown and Company, 1960. Price, $10.50.

This is a record of the scientific proceedings concerning a discussion on the basic processes of immunity, sensitization, and antibody production. Thirty-two world authorities in their respective fields participate in this rather highly technical discussion.

The book follows the format of most of the series from the Ciba Foundation. It is particularly recommended for allergists and immunologists.

R.W.B.

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BOOKS RECEIVED

THE HUMAN FRAME. By Giovanna Lawford With a Foreword by Dr. Margaret Mead. Anchor Books. Garden City, New York: Doubleday & Company, Inc., 1961.

EPIDEMIC. By Frank G. Slaughter. Garden City, New York: Doubleday & Company, Inc., 1961. Price, $3.95.

SQUIBB PRODUCT REFERENCE. For The Medical Profession. Janaury, 1961.

P-Q-R-S-T, A GUIDE TO ELECTROCARDIOGRAM INTERPRETATION. Fourth Edition. By Joseph E. F. Riseman, M.D., Assistant Clinical Professor of Medicine, Harvard Medical School; Visiting Physician, Beth Israel Hospital, Boston, Massachusetts. New York: The Macmillan Company, 1961. Price, $6.50.

FROM FISH TO PHILOSOPHER. The Story of Our Internal Environment. By Homer W. Smith. Ciba Edition, Revised and Enlarged.

PRACTICAL CLINICAL MANAGEMENT OF ELECTROLYTE DISORDERS. By William J. Grace, Director of Medicine, The St. Vincent's Hospital of the City of New York; Professor of Clinical Medicine, New York University School of Medicine. Formerly, Associate Professor of Medicine, Cornell University Medical College. Appleton-Century-Crofts, Inc. New York. $4.95.

ILLUSIONS AND DELUSIONS OF THE SUPERNATURAL AND THE OCCULT. (The Psychology of the Occult). By D. H. Rawcliffe. New York, N. Y.: Dover Publications, Inc., 1961.

LETTERS TO MY SON. By Wendell J. S. Krieg, Professor of Anatomy, Northwestern University Medical School. Evanston, Illinois: Brain Books, 1961. Price, $3.00.

BASIC FACTS OF BODY WATER AND IONS. By Stewart M. Brooks, M.D., Science Instructor, Lasell Junior College, Auburndale, Mass.; Instructor in Pharmacology at Boston City Hospital School of Nursing, and Children's Hospital School of Nursing, Boston, Mass. New York, N. Y.: Springer Publishing Company, Inc., 1961. Price, $2.75.

A POLYCHROME ATLAS OF THE BRAIN STEM. By Wendell J. S. Krieg, Professor of Anatomy, Northwestern University Medical School. Chicago: Northwestern University Press. Price, $3.00.

REGULATION OF THE INORGANIC ION CONTENT OF CELLS. In honor of Prof. E. J. Conway. Ciba Foundation Study Group No. 5. Editors for the Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Cecilia M. O'Connor, B.Sc. 16 illus. Boston: Little, Brown and Company, 1961.

NEW AND NONOFFICIAL DRUGS. An Annual Compilation of Available Information on Drugs, including Their Therapeutic, Prophlactic and Diagnostic Status, As Evaluated by The Council on Drugs of the American Medical Association. Philadelphia and Montreal: J. B. Lippincott Company, 1961.

W. K. KELLOGG FOUNDATION ANNUAL REPORT, 1960.

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the Journal
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Volume 60 Number 5

May, 1961

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THE COVER

The new Michigan State Medical Society headquarters building in East Lansing will be dedicated Sunday, June 4. Every MSMS member and his lady are cordially invited to attend.

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President's Page

ADDED USEFUL YEARS



Kenneth H. Johnson

President
Michigan State Medical Society

"There are many facets of medical care, ranging from the ultimate in scientific aims such as solving the problems of a specific disease entity like 'rheumatic fever'—to pure economics such as bargaining between management and labor with medical care as one of the fringe benefits. This latter situation can be emphasized by repeating what was once stated to one of our committees while we were seeking a solution to some of these problems. A representative of management stated: 'No matter how worthwhile or good your program may be, I can only say that at the bargaining table it is decided on whether it costs a nickel more or a nickel less.'

"Between these two extremes occur a great variety of situations which require careful judgment to resolve. It is unfortunate when emotions interfere with such judgment, but it does happen occasionally. One of these situations is the business of living past age 65, a matter of increasing concern since more people live longer than used to be so.

"The Michigan State Medical Society has had a ten-point program for some time which we believe could best solve the problem of those over 65 years of age.

"MSMS also has a Presidents Program, an ambitious one, covering the next five years, in which we will take the lead but are counting strongly on help from a great number of different organizations to put over. This program is aimed at adding useful years to the lives of all citizens of this State.

"The AMA also has its ten-point plan of promoting the best health care possible for the citizens of this country. The AMA is studying every aspect of medical care costs and when finished will report to the public and the profession. It is dedicating its efforts to promote positive health objectives for older people with flexible retirement policies, home care programs and nursing homes designed for the elderly and others, and the AMA has many other activities.

"Physicians are proud of the fact that these programs are being initiated by, directed by and implemented to a great degree by the profession of medicine. There is nothing in their implementation which asks or puts the responsibility on government to run, although some of them ask government's cooperation. While we would be proud to have the help of any particular group, we feel this is our job and we should like to do it."

Excerpts from an address by President Johnson at the annual meeting of the Michigan League for Nursing, March 23.

New Headquarters Building Dedication, June 4



Eager for new opportunities to improve MSMS services to members and to the general public, the Michigan State Medical Society will dedicate its new headquarters building Sunday, June 4.

Every member of MSMS is cordially invited to participate in the afternoon ceremonies. The dedication program will provide the opportunity, too, for MSMS to explain new plans to expand and improve its operation.

Certainly, the MSMS Presidents Program is timely as it develops ways to "increase the potential productivity and usefulness of additional years of life."

To further quote Resolution No. 25 of the 1960 MSMS House of Delegates instituting the Presidents Program, it stated that "the facilities of the headquarters shall serve as the campaign 'control center' for the ambitious five-year plan." The conference rooms at the new headquarters, for example, will permit effective planning sessions with other groups and will ideally serve all MSMS committees with records and materials at their finger tips.

* * *

THE NEW MSMS headquarters is ideally suited for use by busy physicians. Situated at Highway M-78 and Abbott Road in East Lansing, the headquarters will be readily accessible from all points without hindrance from heavy city traffic. The new headquarters' parking area will accommodate 50 cars and can be expanded if needed.

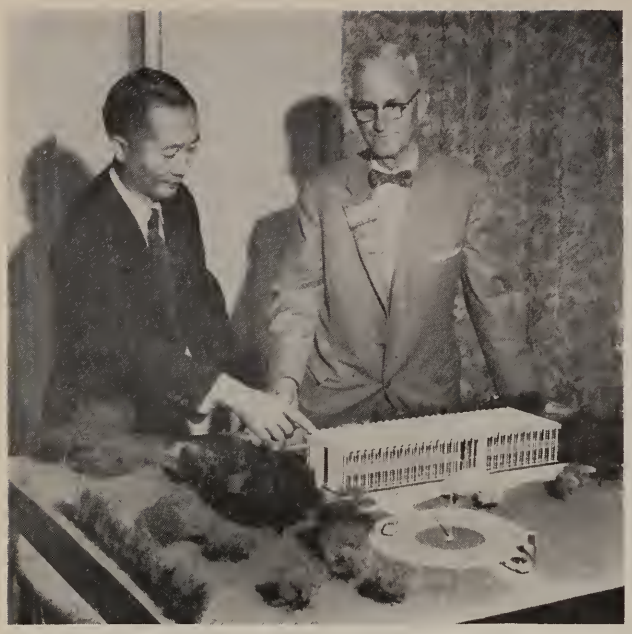
Fine residential areas surround the MSMS property, with Whitehills Estates immediately to the east and north. Since the purchase of this site, the Michigan Education Association has obtained nearby land on which it intends to construct a new office building in the near future. Another neighbor is the East Lansing Presbyterian Church.

As the doctor or other visitor enters the building, he will be greeted by a receptionist-telephone operator located in the center of a commodious lobby, two stories high. This area is the hub of the building and no office is more than 40 feet distant.

* * *

ON THE FIRST floor are located the offices of the MSMS President, business manager and bookkeeper, and an extra office for future growth. Also, in the western wing is located the stenographers' room and an all-purpose room which may be used for large committee meetings or educational gatherings.

The lower level contains workshops and storage rooms. For example, all mail will be processed there in a special room equipped with the latest devices to speed important correspondence to MSMS members. Here, also, will be rooms to store radio transcriptions, pamphlets, and the motion picture films from the PR Library, cleaning



A scaled model of the new headquarters was effective to help MSMS visualize the new building during the early stages of the Big Look Committee work. Architect Minoru Yamasaki explains a feature to William S. Jones, M.D., chairman of the Big Look Committee.



The groundbreaking ceremony was April 1, 1959 with members of The Council and guests participating. Turning the first shovel is G. B. Saltonstall, M.D., then President. Watching are Kenneth H. Johnson, M.D., left, then Speaker of the House, and D. Bruce Wiley, M.D., right, then Chairman of The Council.

and repairing of films will be performed here also. In addition, recording equipment, tape recorder, and other audio-visual equipment will be set up in a specially designed room which subsequently can be used for motion picture production, radio and television broadcasting.

* * *

THE SECOND FLOOR will house the Directors Room, and a connecting smaller Committee Room which will provide ample space for even the largest MSMS committee meeting. Opposite this, the executive director and his assistant will be installed. The files of the Director's office thus will be at the immediate disposal of meetings in the Directors Room.

Down the hall is the Public Relations Library, crammed with research data, periodicals, surveys, 11



MSMS memorabilia was sealed into the cornerstone at the cornerstone-laying ceremony September 27, 1959 by G. B. Saltonstall, M.D., then President, assisted by Milton A. Darling, M.D., then president-elect, and A. E. Schiller, M.D., then chairman of The Council.



A progress photo of the headquarters before the pre-formed concrete columns and roof vaults were swung into place.

years of news clippings, reference works, audio-visual material for TV or speech presentations and education tape recordings. A part-time librarian will be on hand to efficiently operate this MSMS service to members. Other offices serve the public relations counsel, the assistant to the executive director and field secretaries.

* * *

THE ARCHITECT for the new headquarters building was Minoru Yamasaki, AIA, of the firm Minoru Yamasaki & Associates, of Birmingham.

The firm of Minoru Yamasaki & Associates has been cited by the American Institute of Architects and other organizations. Mr. Yamasaki was born in Seattle, Washington, and received his Bachelor of Architecture at University of Washington. His graduate work was taken at New York University, where he also served as instructor.

* * *

WM. S. JONES, Sr., M.D., chairman of the MSMS Big Look Committee, said, "On May 31, 1959, MSMS membership totaled 6,211—an increase of almost 2,000 members in eight years. The Townsend building has served us well, but we have outgrown it. The new headquarters has been planned with conservative foresight. We believe that our present and future needs are provided for and that the medical profession will have just cause for pride in its new and modern quarters."

Twenty-six years ago, the MSMS headquarters consisted of two small offices on the 20th floor in Lansing's tallest building, then known as Olds Tower. A staff of three, including the new Executive Secretary, Mr. William J. Burns, served the 3,410 members then listed in the MSMS roster.

"2020 Olds Tower" was the familiar address of MSMS for the next 16 years. During that time, the membership had grown to 4,667. Eight employes were handling the organizational and educational details of the association. In 1951, for reasons of economy and efficiency, MSMS left its downtown address and purchased a converted residence at 606 Townsend Street. In recent years, every available foot of floor space was filled with equipment, personnel and records. Not only has membership grown, but the demand for MSMS services has multiplied too.

The new headquarters building was designed to better serve the medical profession and the public. The structure symbolizes the dignity and high purpose of the medical profession. It was erected in tribute to the past and dedicated to the future.



"606 Townsend" served MSMS well, from 1951 until "moving day" on April 24. Every available foot of space was being used in the remodeled residential building from the basement production rooms to the attic rooms for five staff members.

On AMA Program

Advance programs issued for the American Medical Association's 110th annual meeting in New York City, June 25-30, lists a Michigan doctor on a panel discussion on "Renal and Adrenal Hypertension." The program combining General Surgery, Internal Medicine, Pathology and Physiology, Urology and General Practice, will offer a panel, including Marion S. DeWeese, M.D., Ann Arbor.

Another Michigan man is listed on early AMA plans. Talking about "Objective Measurement of the Effects of Drugs on Driving Behavior" will be James G. Miller, director, Mental Health Research Institute, University of Michigan.

Upper Peninsula Society Program Set June 16-17

An impressive program has been arranged for the 66th annual meeting of the Upper Peninsula Medical Society, June 16 and 17 at the Silver Dome Hotel-Motel at Marinette, Wisconsin.

The list of speakers will be headed by Kenneth H. Johnson, M.D., Lansing, president of the Michigan State Medical Society.

Others obtained for the event include William Kelly, M.D., Lansing; John Sheldon, M.D., and Harry Towsley, M.D., both of Ann Arbor; Ovid Meyer, M.D., Madison; Donald Moore, M.D., Bloomington; Merle M. Musselman, M.D., Lincoln, Nebraska; Oliver Rian, M.D., Peoria, Illinois, and H. W. Gintz, of the Medical Protective Company.

The Menominee County Medical Society will serve as host for the annual meeting.

Officers of the U. P. Society include John Heidenreich, M.D., Daggett, president; John R. Franck, M.D., Wakefield, president-elect, and George H. Hopson, M.D., Menominee, secretary-treasurer.

HIGHLIGHTS of The Council

Meeting of March 17, 1961

One-hundred and twenty items were presented to and discussed by The Council at its March 7 meeting in Detroit. Chief in importance were:

- Progress Report on new MSMS Headquarters Building. President Johnson stated the contractor would be out of the building the latter part of March which would permit the carpet people to begin work, following which, the furnishings would be installed. Goal for moving into the new building was set for April 25.

 Memorial contributions were increased by the offer of $500 from Mr. Lyle O. Wellman of Wellman Press, Lansing. Other donors, besides the Past Presidents and the Woman's Auxiliary, are Mrs. L. Fernald Foster, Detroit, $1,000; Dr. and Mrs. W. S. Jones, Menominee, $1,000; the Shook Family of Kalamazoo, $1,000; and Bruce Publishing Company of St. Paul, $1,000.
- Report from H. A. Towsley, M.D., Ann Arbor, on meeting of Council on Education and Hospitals, Chicago, February 4, was accepted with thanks and referred to the Editor for publication in JMSMS.
- D. L. Hinerman, M.D., Ann Arbor, Chairman of a committee for U-M Department of Postgraduate Medical Education engaged in a comprehensive review of postgraduate medical education, requested suggestions and recommendations from members of The Council for evaluation of past performance and the future needs of postgraduate medical education in Michigan. Doctor Hinerman was requested to send copies of the questionnaire to every member of The Council.
- Homer A. Stryker, M.D., Kalamazoo, was selected as Biddle Lecturer by President Kenneth H. Johnson, M.D.
- Support of Martin Fleming and Emily Sargent, both of Detroit, for reappointment by the Governor to the Michigan Crippled Children Commission was authorized.
- A proposed letter drafted by President Kenneth H. Johnson, M.D., for mailing to all MSMS members re the dangers and seriousness of the present situation in regard to attacks against medicine, was approved.
- M. H. Chapin, M.D., of Millington, requested permission to join Genesee County Medical Society because of proximity of Millington to Flint. The Council approved this request.

 Morton J. Wiener, M.D., of Ferndale, wishes to continue Wayne County Medical Society membership although his office is now in Oakland County on the border (WCMS membership committee has approved this request). The Council also gave approval.

 J. L. Tromp, M.D., of Lake Odessa, desires to transfer his membership from Ionia-Montcalm to the Barry County Medical Society because he is on the county border and has most of his affiliations in the Barry County area. The Council approved this request.
- Legal Counsel Lester P. Dodd presented five matters: (a) motion for a new trial has been made by Gonsertron of Bay City; (b) Mr. Dodd has prepared a brief on the advantages and disadvantages of incorporation of county medical societies; (c) information on Michigan's privileged communications statute and medical practice act was prepared and forwarded to Connecticut State Medical Society; (d) opinion re applicability of rules of evidence in proceedings before a county society ethics committee; (e) opinion (for MSMS Committee on Prevention of Highway Accidents) re legal implication of setting up county medical society advisory boards for medical re-evaluation of unfit driver.
- Public Relations Counsel reported on medical and health legislation, both federal and state; staffing of state fair exhibit; co-operation of MSMS with component societies wishing to extend awards to winners in local science fairs was approved; progress on study of single medical practice act was reported.
- 1961 Michigan Clinical Institute. Executive Director Burns reported on anticipated high registration at Discussion Conferences, a new feature of the 1961 MCI.
- Committee Reports. The following were given consideration: Child Welfare, meeting of December 8, 1960; Liaison Committee with Michigan Chapter of Health Insurance Council, January 25; Public Relations Committee, January 28; Committee to Survey Utilization of Health Insurance, February 1; Arrangements Committee for Residents-Interns-Senior Medical Students Conference, February 2; Advisory Committee to Executive Director, February 23; Medical Care Insurance Committee and RVS Study Committee, February 25-26; Geriatrics Committee, January 24. Other committee reports

(Continued on Page 564)

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Highlights of The Council

(Continued from Page 562)

presented were: Michigan Joint Council to Improve Health Care of the Aged, December 13; and Permanent Conference Committee, December 14.

- Michigan Medical Service. Matters of mutual interest and information were presented and discussed with Blue Shield President G. Thomas McKean, M.D., of Detroit, who introduced to The Council Mr. Sumner G. Whittier, Executive Vice President of Blue Shield.

 L. Gordon Goodrich of Blue Shield presented progress report on the Veterans Administration Hometown Medical Care Program, and also submitted contract for renewal of Medicare which was approved by The Council.
- Robert A. Reath, head of the Medical Television Unit of Smith, Kline and French Laboratories of Philadelphia, was introduced to The Council; Mr. Reath expressed his enthusiasm for the MCI television program and arrangements.
- Appointment of Committees. (a) Committee to Meet with Wayne County Medical Society Representatives to Resolve Question of MSMS Speakers appearing in Wayne County was appointed with R. W. Teed, M.D., Ann Arbor as Chairman; (b) Study Problem of Recruitment for Medical Careers: this matter was referred to the Subcommittee on Recruitment of the Public Relations Committee; (c) 1961 House of Delegates News Committee was appointed: J. J. Lightbody, M.D., Chairman, H. F. Falls, M.D., Ann Arbor, D. Bruce Wiley, M.D., Utica, and C. Allen Payne, M.D., Grand Rapids; (d) Scientific News Committee for 1961 Annual Session in Grand Rapids: H. G. Benjamin, M.D., Chairman, F. S. Alfenito, Jr., M.D., J. A. Ferguson, M.D., F. C. Brace, M.D., P. W. Kniskern, M.D., all of Grand Rapids, and A. B. Gwinn, M.D., of Hastings, and C. L. Weston, M.D., of Owosso.

 Committee on Scientific Exhibit for 1961 Annual Session is to be headed by J. R. Lentini, M.D., of Grand Rapids.
- MSMS Representatives to AMA Legislative Conference, March 18-19, Chicago: President Kenneth H. Johnson, M.D., Lansing, President Elect Otto K. Engelke, M.D., Ann Arbor and Legal Affairs Chairman L. A. Drolett, M.D., Lansing, were authorized to attend this Conference as AMA guests; in addition, Finance Committee Chairman O. B. McGillicuddy, M.D., of Lansing, and Messrs. H. W. Brenneman and M. A. Riley were authorized to attend.
- Upper Peninsula Medical Society, June 16-17, and the AMA Annual Meeting, June 26-30: Representatives to attend these two meetings were authorized.

Report on AMA Council On Education and Hospitals

The February 4 meeting of the AMA Council on Education and Hospitals in Chicago was limited to representatives of the Council on Education and Hospitals and representatives from some nine states in the Chicago area. The meeting was introduced by Dr. McKittrick and hope expressed that there would be a free interchange of ideas as to how the Council on Education and Hospitals could be of greater service to the State Societies.

Dr. Caldwell gave a brief discussion of some of the functions of the Council in regard to internship and residency programs; such as:

1. developing the Essentials of the approved residency and Essentials of the approved internship as to standards of training required in these areas—
2. developing methods of inspection of hospitals applying for intern and residency approval—
3. development of intern and residency review committees to review applications of hospitals applying for such approval.

Dr. Wescoe, another member of the Council who is Vice Chancellor at the University of Kansas Medical School, presented briefly the Council's activities in: (1) the recruitment of students, (2) the availability of scholarships and loans, and (3) discussed in general the problems of financing medical education. He further pointed out that the Council made surveys of each of the medical schools about every seven years to ascertain the general policy of the curriculum, the availability of teachers and several other problems concerning medical education as it related to the particular school. He indicated that such visits were not made on a policing basis but rather with the idea of offering helpful criticism and suggestions to improve and raise the standards of medical education.

Dr. John Z. Bowers, a third member of the Council and Dean of the University of Wisconsin, discussed the Council's roll as it related to allied medical professions; for example, the ophthalmologist and optometrist, the psychologist and psychiatrist, the pathologist and clinical laboratory worker. His committee had to do the accrediting programs in related health professions in physical therapy, medical technology, x-ray technology, medical libraries, etc.

Dr. Walter S. Wiggins, a member and secretary of the Council, discussed the council's activities in relation to foreign graduates and ways and means by which members of the Council might help to up-grade the caliber of foreign medical education.

After these general discussions, Dr. McKittrick

pointed out that the Council would be most receptive to suggestions from members present as to how the Council might be of greater service to each state and county medical society in the above mentioned areas. One suggestion made seemed to be quite acceptable—that State Societies have matching committees comparable to the Committee on Education and Hospitals. Such a committee should be well-balanced with physicians interested in education and in practice, who would be in position to assist the Council on Hospitals and Education of the American Medical Association by: (1) creating better dissemination of the Council's deliberations in the line of communication to the "grass roots", (2) to be able to assist the Council in developing better training programs within the hospitals of the State, (3) to provide better co-ordination in developing methods of financing medical educations, (4) making it possible to interest more physicians in the problems of recruiting students to the health fields.

I believe there are not more than five or six county medical societies in Michigan now having some type of loan funds or scholarships for medical students. This is an area very much in need of development and expansion and I believe that by using the facilities of the Council and their "know how" we could successfully broaden these areas in the State of Michigan.

HARRY A. TOWSLEY, M.D.

Speak to Clubs

Nine talks were presented by MSMS members in conjunction with the 1961 MCI. The addresses were given to service clubs in the Metropolitan Detroit area.

The list included C. H. Ross, M.D., Ann Arbor, who addressed the Detroit Kiwanis No. 1 Club, on "Male Change of Life;" K. L. Krabbenhoft, M.D., Detroit, the Excalibur Club, on "Radiation Protection and Nuclear Medicine;" L. A. Pratt, M.D., Detroit, the Kiwanis Club of Central Detroit, on "Lung Cancer and Its Relation to Smoking;" A. Blain, III, M.D., Detroit, the Detroit Group Representatives Association, on "Rising Insurance Cost, Over Utilization of Insurance and Increased Cost of Hospital Care and Doctors' Fees;" D. A. Sargent, M.D., Detroit, the Exchange Club of Detroit, on "The Relationship to, and Society's Responsibilities for, Mental Illness to Crime"; Lewis Hoffman, M.D., Detroit, the Christ Memorial Ev. Lutheran Church Men's Club, on "Who Needs a Psychiatrist;" C. J. Hipps, M.D., Detroit, the Royal Oak Exchange Club, on "Plastic Surgery;" G. S. Beckett, M.D., Detroit, the Caravan Shrine Club, on "Psychiatry;" and J. G. Bielawski, M.D., Detroit, the Cass Tech Pre-Med Club, on "Development of the Heart."

What They Said About 1961 MCI

"I wish to take this opportunity to thank you and your staff for your supreme and indefatigable efforts in connection with our Program Committee for the Michigan Clinical Institute. I would think that the Discussion Group's program could be expanded for next year as long as there is a careful selection of subject material."

JOHN W. SIGLER, M.D., Detroit

"Having arrived home safely, I hasten to let you know how much I enjoyed participation in the meeting in Detroit. It seemed to me a very well attended and excellently planned meeting and I believe your organization should be congratulated on such fine arrangements."

JOHN L. KEELEY, M.D., Chicago
(Guest Essayist)

"I want to thank you for the opportunity to participate in your recent meetings of the Michigan Clinical Institute and to congratulate you upon the hospitality that was shown me by my host."

ALVIN L. WATNE, M.D., Buffalo, N. Y.
(Guest Essayist)

"I want to thank you for everything that you did for me during my visit to the Michigan Clinical Institute and for the privilege of presenting the Pharmaceutical Lecture. The visit was a very pleasant one for me."

CHESTER S. KEEFER, M.D., Boston
(Guest Essayist)

"I am writing to express my most grateful thanks for the wonderfully cordial and hospitable manner in which I was treated on the occasion of my participation in the recent Michigan Clinical Institute. This entire experience was a most satisfying one which I enjoyed immensely. All of the arrangements which were made in advance on my behalf contributed enormously to the ease of my participation."

D. N. DANFORTH, M.D., Evanston, Ill.
(Guest Essayist)

"I want to express my thanks for being invited to participate in the program. I was very impressed with the program this year and I think that it offered many opportunities for the physicians, not only in general practice but in the specialty areas, to learn from the panel arrangement type of discussions that were presented.

R. W. BAILEY, M.D., Ann Arbor
(Guest Essayist)

"My wife and I, thanks to you and your group, had a most enjoyable stay in Detroit. The meeting was very stimulating and I carried away from it a good deal more than I brought to it.

"Thanks again for your warm hospitality and the pleasure of having met so many stimulating doctors."

EDWARD C. MANN, M.D., New York City
(Guest Essayist)

(Photo below)

Leaders for an evening symposium about the older person prepare to take the platform. A Hazen Price, M.D. *(standing)*, Detroit, was the chairman, aided by *(left to right, seated)*, A. H. Hirschfeld, M.D., Detroit; Raymond W. Waggoner, M.D., Ann Arbor, and Jack Weinberg, M.D., Chicago.





Mrs. Esther G. Regnaert *(left)*, Grosse Pointe Farms, chairman for the Fourth Annual Educational Seminar for the Michigan State Medical Assistants Society, studies the Seminar program with Mrs. Betty Lou Willey, Port Huron, MSMAS president.

Photos Help to Tell MCI Story



Eight Discussion Groups, an innovation this year at MCI, drew fine attendance at 8 a.m. in the morning! Directing the discussion on "Newer Drugs in the Treatment of Pregnancy Toxemia" were *(left to right)*: Charles S. Stevenson, M.D., Detroit; David N. Danforth, M.D., Evanston, and Arthur G. Seski, M.D., Detroit.



A citation was presented to Charles P. Bailey, M.D. *(left)*, New York, a pioneer in surgery of heart valve, by Earle Ingham Carr, M.D., Lansing, president of the Michigan Foundation for Medical and Health Education. Doctor Bailey gave the MFMHE Lecture, an annual MCI highlight.



The annual Conference for Residents, Interns and Senior Medical Students took a look at the costs of medical education. Panel patricipants *(left to right)*, were: Dean G. H. Scott of the Wayne State University School of Medicine; Associate Dean J. C. Caughey, M.D., Western Reserve School of Medicine; Wm. Bromme, M.D., Detroit, moderator for the panel; Dean W. N. Hubbard, M.D., of the University of Michigan Medical School and Walter S. Wiggins, M.D., Chicago, AMA Council on Medical Education secretary.



The annual Michigan Cancer Coordinating Committee Lecture was presented by Anthony R. Curreri, M.D. *(center)*, Madison, Wisconsin, who received a certification of appreciation from James W. Hubly, M.D., Battle Creek, chairman of the Cancer Coordinating Committee. At left is Harry N. Nelson, M.D., Detroit, former chairman.

MCI Attendance Report

Final attendance figures for the 1961 Michigan Clinical Institute hit 2,626, including 1,450 doctors of medicine. Further study of the figures reveals that sixteen different specialties were represented and that doctors attended from 157 different Michigan communities. The breakdown is as follows:

REGISTRATION BY SPECIALTIES

	Wayne County	*Outstate*
Anesthesiology	6	2
Dermatology-Syphilology	3	—
Gastroenterology-Proctology	12	6
General Practice	187	172
Medicine	75	39
Nervous and Mental	6	9
Obstetrics-Gynecology	73	30
Occupational Medicine	12	4
Ophthalmology	9	2
Otolaryngology	2	4
Pathology	10	5
Pediatrics	99	60
Public Health	7	18
Radiology	4	2
Surgery	89	75
Urology	2	—
Residents and Interns	215	66
Specialty not given	73	74
	884	568

M.D.'S OUTSIDE OF MICHIGAN

Canada	29	Missouri	1
Illinois	6	New Jersey	1
Indiana	2	New York	3
Kentucky	1	Ohio	6
Maryland	1	Oklahoma	1
Massachusetts	2	Wisconsin	1

MICHIGAN M.D.'S

Adrian	3	Belleville	2
Allen Park	5	Berkley	2
Alpena	4	Birmingham	11
Ann Arbor	43	Brooklyn	2
Bad Axe	3	Cadillac	2
Battle Creek	14	Clare	2
Bay City	9	Clinton	2
Coldwater	3	Midland	9
Dearborn	41	Milan	2
Detroit	708	Monroe	9
Drayton Plains	2	Morenci	2
Durand	2	Mt. Clemens	7
Eloise	10	Mt. Pleasant	2
Farmington	4	Muskegon	11
Fenton	3	Newaygo	2
Ferndale	6	Northville	16
Flat Rock	3	Oak Park	6
Flint	52	Owosso	4
Fremont	3	Petoskey	2
Garden City	2	Pleasant Ridge	2
Grand Rapids	30	Plymouth	2
Grosse Pointe	11	Pontiac	22
Grosse Pointe Park	3	Port Huron	7
Grosse Pointe Shores	2	Rochester	4
Grosse Pointe Woods	3	Roseville	2
Hamtramck	3	Royal Oak	24
Hastings	4	Saginaw	16
Highland Park	13	St. Claire Shores	8
Howell	3	St. Johns	2
Hudson	2	Southfield	3
Inkster	3	Tecumseh	4
Ishpeming	3	Traverse City	5
Jackson	18	Utica	2
Kalamazoo	12	Warren	4
Lansing	41	Wayne	6
Lapeer	7	Wyandotte	14
Lincoln Park	5	Ypsilanti	6
Livonia	3	(Towns represented by one*)	79
Ludington	2		
Manistique	2		
Marquette	2	TOTAL	1452

*One (1) member attended from each of the following cities; Alma, Albion, Auburn Heights, Bangor, Birch Run, Breckenridge, Boyne City, Bridgeport, Brown City, Byron Center, Clarkston, Calumet, Capac, Cass City, Coleman, Charlevoix, Coopersville, Clawson, Chatham, Chelsea, Douglas, Essexville, East Jordan, Ecorse, Fowlerville, Frankenmuth, Grosse Pte. Farms, Grand Haven, Gaylord, Gladstone, Goodrich, Greenville, Grand Blanc, Huntington Woods, Harbor Beach, Hazel Park, Hillsdale, Hesperia, Holly, Holland, Hartford, Hemlock, Keego Harbor, Kalkaska, Lathrup, Linden, Lowell, Laurence, Manistee, Menominee, Middleville, Mt. Morris, Marshall, New Baltimore, Oakland, Onaway, Orchard Lake, Olivet, Rogers City, Remus, River Rouge, Richmond, Reed City, Southgate, Saugatuck, Sandusky, St. Ignace, Sanford, Sparta, Sturgis, St. Louis, Swartz Creek, Three Rivers, Trenton, Taylor, Williamston, Whitehall, Yale, Zeeland.

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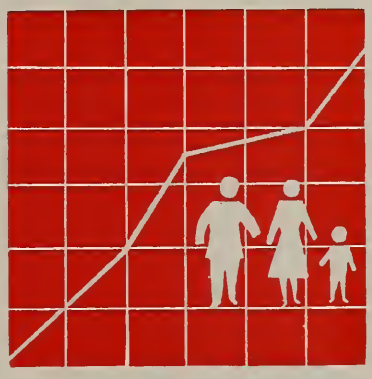
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More than 120 million Americans, or two-thirds of the nation's civilian population, have achieved a substantial degree of financial security by protecting themselves with health insurance policies.

An estimated 132 million persons have hospital expense insurance, 120 million persons have surgical expense insurance, and 43 million workers—through formal plans—have their earnings protected by loss-of-income insurance. Millions of other workers had some degree of income protection through informal arrangements.

Major medical, little more than ten years old, now covers some 25 million persons.



Michigan Blue Cross Payments Hit New Record

Record payments of nearly $143-million for hospital care for Michigan Blue Cross members in 1960 put the plan in the red despite a record low operating cost of less than 3.5 per cent of income. The 22nd annual Blue Cross report said an increase in hospital costs coupled with needed use of more services by more members sent outgo over income by $1,724,000 (M) with that amount drawn from reserves.

The 1960 payments to hospitals hit $142,743,000 (M), 8.3 per cent higher than 1959. However, income, geared to a rate set in January of 1959, remained virtually unchanged. The report said hospital admissions for Blue Cross members hit an all-time high of over 576,000.

Joins Blue Shield Plan

Medical Mutual of Cleveland, Inc., a medical-surgical Plan serving a five county area in northeastern Ohio, has been accepted as an active member of the National Association of Blue Shield Plans. The Cleveland-based Plan, which now can use the Blue Shield symbol and name, was organized in 1945 and has enrolled more than 1,115,000 members since then.

Medical Mutual of Cleveland brings to 75 the number of Blue Shield Plans and affiliates in the United States and Canada.

Michigan Health Council Holds Conference

The Michigan Health Council State Conference will be held at Flint Junior College May 23-May 25, 1961. This year the Conference includes the 13th Annual Michigan Rural Health Conference, the 3rd Annual Michigan Health Careers State Conference, and the 1st Michigan Conference of the Joint Council to Improve the Health Care of the Aged.

Conference officials are Harry A. Towsley, M.D., Ann Arbor, General Chairman, and John A. Doherty, East Lansing, Secretary.

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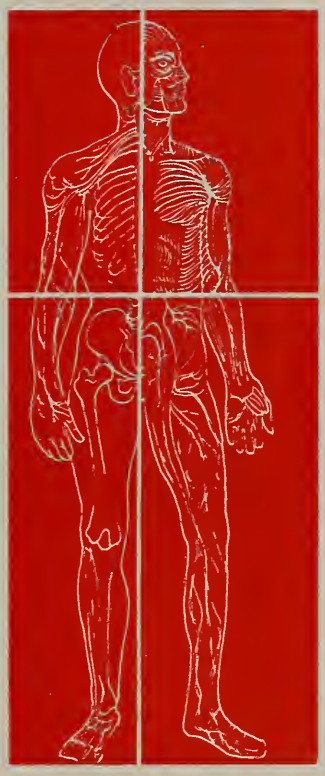
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Say you saw it in the Journal of the Michigan State Medical Society

Pancreatitis: A Clinician's Viewpoint

John B. Gross, M.D.
Rochester, Minnesota



CLINICALLY, three principal forms of pancreatitis are recognized: (1) acute edematous, interstitial, (2) acute hemorrhagic, necrotic, and (3) chronic. The clinical picture of each of these three forms will be surveyed briefly herein, and the matter of diagnostic criteria then will be considered. Certain special aspects of pancreatitis have been emphasized recently and deserve some comment. Finally, the management of patients with pancreatitis will be discussed.

Clinical Varieties

Acute Edematous Pancreatitis.—It seems possible that mild, *edematous* pancreatitis occurs more frequently than is appreciated. Every physician has encountered persons who could recall having experienced one or more isolated episodes of mild or moderate, steady, boring transepigastric pain, persisting all day and into the night, and unattended by chills, fever or jaundice. Often, slight epigastric tenderness has been associated. Such attacks may not have been severe enough to warrant calling a physician, or, if such was done, the diagnosis may have been pylorospasm, "gastritis" or "acute indigestion." Roentgenologic studies later may reveal no evidence of gallstones or peptic ulcer. Many such instances probably represent evanescent, mild edema of the pancreas which has escaped recognition.

Attacks of the sort just described, but more severe, may result in admission of the patient to the hospital. Determination of the serum amylase during the acute attack commonly will afford evidence to corroborate the clinical suspicion of pancreatitis. If acute cholecystitis is the working diagnosis, laparotomy is performed. Usually no stones are found in the gallbladder, although the organ may appear to be mildly inflamed, and the pancreas is described as being "slightly thickened." As a rule, the surgical findings are unimpressive, and there is no evidence of hemorrhage or parenchymal necrosis. It is this variety of pancreatitis about which Elman and Archibald wrote some thirty years ago.

There is circumstantial evidence to support the concept that acute edematous pancreatitis may occur and pass unrecognized, apparently unaccompanied by pain of note. Evans and associates found no men-

Read at the meeting of the Michigan State Medical Society, Detroit, Michigan, September 27, 1960.

From the Section of Medicine, Mayo Clinic and Mayo Foundation. The Mayo Foundation, Rochester, Minnesota, is a part of the Graduate School of the University of Minnesota.

tion of abdominal pain in the records of fifteen of twenty-five cases in which acute or subacute interstitial pancreatitis was detected incidentally at necropsy.

Mild attacks of pancreatitis, such as described, generally do not require hospitalization and often a physician is not consulted. At most, analgesia and simple supportive measures suffice.

Acute Hemorrhagic Pancreatitis.—The clinical picture in those afflicted with acute *hemorrhagic* pancreatitis is in sharp contrast to that just described, for in such cases there is no doubt that something dramatic has occurred, and the patient is hospitalized promptly. The upper abdominal pain is acute, progressively more severe, steady, and prolonged; attacks may persist for days. The abdomen is tender, and evidences of peritoneal irritation and shock are the rule. If looked for, Turner's sign may be apparent in the loins during the attack. Nausea, vomiting and low-grade fever often occur, and usually mild-to-moderate polymorphonuclear leukocytosis is found. Values for amylase in the serum and urine, as well as for serum lipase, may increase tenfold or more during the attack. Hypocalcemia, thought to result mainly from deposition of calcium in areas of fat necrosis which involve the pancreas and which may be widespread throughout the peritoneal cavity, is common; values less than 7 or 7.5 mg. per 100 ml. of serum portend a poor prognosis.

The management of such patients is a joint project for physician and surgeon, although reasonable certainty in regard to the diagnosis calls for continued application of conservative measures designed to relieve pain, put the pancreas at rest, restore the blood volume to normal, combat hypocalcemia and support the patient otherwise by the intravenous administration of fluids, glucose, electrolytes and vitamins. Cortisone is not indicated. Antibiotic agents may be useful, as noted later.

The consensus is that operative intervention is indicated when: (a) there is doubt concerning the diagnosis, and some other acute intra-abdominal catastrophe is suspected, (b) stone in the common bile duct is likely and (c) the complications of abscess or pseudocyst of the pancreas supervene.

If gallstones are demonstrable or known to be present, cholecystectomy should be performed, usually after the acute attack has subsided.

Acute hemorrhagic pancreatitis has proved fatal in a minority (25 to 30 per cent) of cases.[24] Although measures designed to maintain an adequate blood volume during the attack may aid in reducing mortality, as has been stressed by Elliott and associates, the occasional patient, overwhelmed by fulminating pancreatitis, does not survive, despite all therapeutic efforts.

Chronic Pancreatitis.—The clinician recognizes yet another form of pancreatitis: that which evolves over a period of years, in either continuous or relapsing fashion. Chronic, recurrent pancreatitis is the clinical variety of pancreatitis most commonly encountered, in my experience. Most patients seen during an attack of pancreatitis can recall previous similar episodes or will experience such bouts subsequently.

Chronic pancreatitis occurs three or four times more commonly in men than in women. By no means all patients in this category have used alcohol to excess, and gallstones are absent in most.[19] As a rule, chronic relapsing pancreatitis begins in the third or fourth decade of life, and attacks recur over a period of years. Although for most patients painful seizures increase in frequency, duration and severity as the years pass, this quickening of the tempo sometimes does not occur, and such fortunate persons may be comfortable for years between the bouts of pain. Occasionally, one gets the clinical impression that the pancreatitis in a given patient is dormant and likely to remain inactive; in such instances it is commonly said that the pancreatitis has "burned itself out." Still, it is unwise to conclude that in such persons recrudescences may not occur at some future time.

The clinical picture of chronic relapsing pancreatitis has been described in detail previously.[7,18,20] The attacks of pain often vary somewhat in severity, and sometimes are mild enough to suggest edematous pancreatitis, but more often they are severe enough to require repeated injections of opiate over a period of days, thus resembling more the acute hemorrhagic form of the disease. The seizures of chronic relapsing pancreatitis generally are not attended by shock, however, nor are they likely to be lethal.

The pain of pancreatitis is located in the upper part of the abdomen, often beginning in the epigastrium and



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spreading thence into either hypochondrium or both (more characteristically the left), upward into the lower, anterior part of the thorax, and through to the midportion of the back. Generally, the onset of pain is gradual, with progressive increase in the intensity of the pain over a period of several hours. Attacks may begin abruptly, however, sometimes during acute emotional upsets. Characteristically the pain is steady and boring; colicky pain is unusual unless the disease is complicated by stones in the biliary tree. The duration of the pain is an important diagnostic clue, for typically the pain lasts for days at a time—two or three days most often, but sometimes for a week or more. After a number of years of recurrent attacks, a stage often is reached at which one attack merges with another, so that the patient cannot recall having been entirely free of epigastric pain for weeks or months. During the painful seizure the patient often prefers to bend forward or to assume the knee-chest position. Nausea and vomiting, as well as anorexia, are common accompaniments of the acute seizure, although fever generally is low grade and transient or absent altogether.

Epigastric and left subcostal tenderness is the most frequent physical concomitant. Turner's sign is observed uncommonly and lack of rigidity of the abdominal wall is notable.

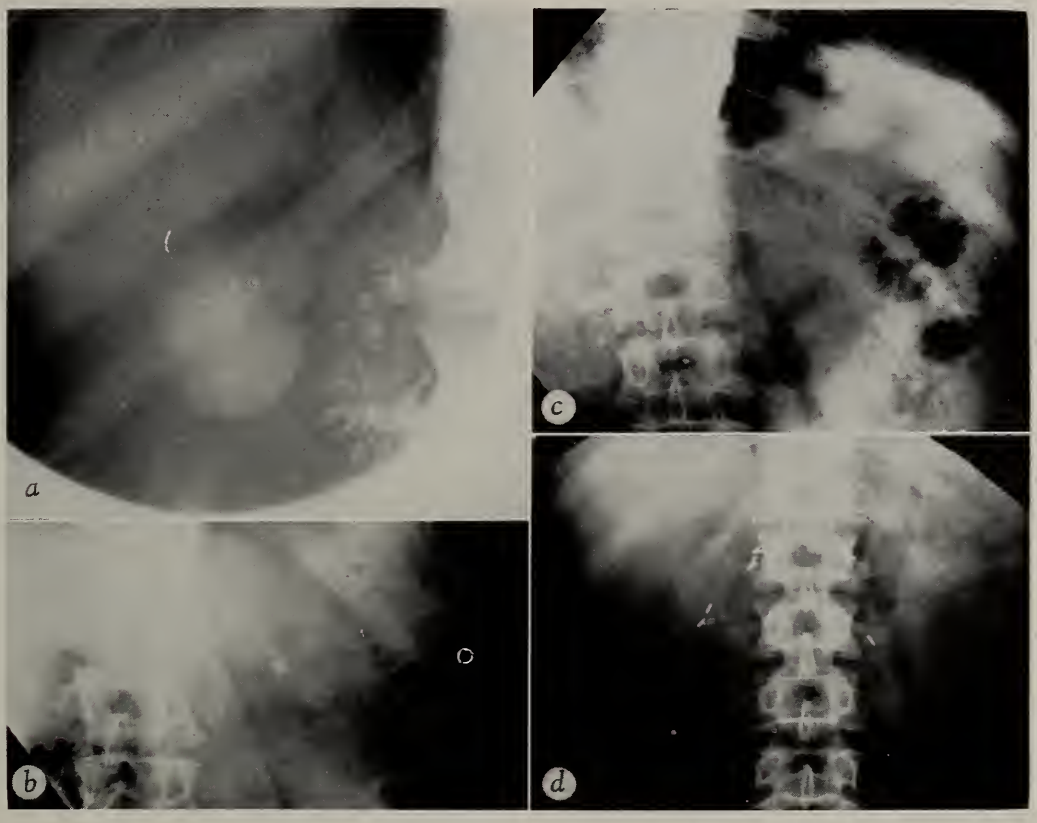


Fig. 1. Pancreatic calcifications, showing various patterns: (a) racemose throughout head of pancreas; (b) miliary and duct stone formed in tail of pancreas 4½ years after removal of several stones from the duct of Wirsung in the head of the gland; (c) amorphous calcific material in the head of the pancreas; (d) small calculi apparently within pancreatic ducts in the head of the pancreas.

As with edematous or hemorrhagic pancreatitis, during acute attacks the values for amylase in the serum and urine usually are increased during the first few days and those for serum lipase may be increased as well. Hypocalcemia is not uncommon; serial determinations show a gradual return to normal values as the attack subsides. Transient hyperglycemia and glycosuria occur occasionally during attacks.

Late in the course of chronic pancreatitis, as parenchymal destruction and fibrosis progress, the sequelae of pancreatitis make their appearance: pancreatic calcifications, external pancreatic insufficiency (steatorrhea and azotorrhea) and permanent diabetes mellitus. These may appear at different stages and may occur singly or in combination. The calcifications

(Fig. 1) sometimes present a lacy, filigree, racemose appearance or may form calculi in the larger pancreatic ducts. Over a period of years the calcifications may increase slowly in size, number and density, and a greater area of the pancreas may be affected. The diabetes caused by pancreatitic destruction of islet cells is similar to that occurring in persons who do not have pancreatitis. Steatorrhea and azotorrhea may be marked enough to be detected by gross examination of the stools; certain demonstration and accurate quantitation, however, depend upon careful performance of intake-excretion studies, especially when the external pancreatic insufficiency is not of marked degree.[11,39]

TABLE I. PANCREATITIS: DIAGNOSTIC CRITERIA

Presumptive
History
"Gray Zone"
History plus increased values for enzymes in serum and urine
History plus surgeon's description
History plus elevations of enzyme content of serum and urine plus surgeon's description
History plus sequelae
History plus family history
Sequelae alone
Surgeon's description
Definite
Surgeon's description (hemorrhage and necrosis)
Pathologic confirmation (alone or with any of above)
Sequelae (especially calcifications)

Chronic pancreatitis may occur without clinically significant pain, as emphasized by Bartholomew and Comfort. This diagnosis is apparent in the occasional patient who undergoes surgical exploration to ascertain the basis for painless jaundice of obstructive type; at operation there may be considerable difficulty in determining whether the pancreatic mass is benign or malignant. In other cases the pancreatitic sequelae of calcifications and steatorrhea, alone or together, may serve to focus attention on the pancreas when pain has been largely lacking. Rarely, the patient may complain only of painless enlargement of the upper part of the abdomen, which results from pancreatic pseudocyst, a complication of pancreatitis.

Diagnosis

In many cases the diagnosis of pancreatitis is not difficult. The history often is sufficiently clear cut and distinctive to enable one to suspect pancreatitis rather strongly. However, on the basis of the history alone only a presumptive diagnosis is possible (Table I). If operation is carried out and pathologic study of excised pancreatic tissue shows edema, hemorrhage, parenchymal or fat necrosis, fibrosis or calcifications, the diagnosis is established. When pancreatic calcifications are demonstrable roentgenologically, the diagnosis also is definite. Clear-cut demonstration of external pancreatic insufficiency likewise erases uncertainty. Diabetes mellitus without other sequelae of pancreatitis is less diagnostic, since diabetes occurs so commonly in the absence of pancreatitis.

As indicated in Table I, there is a sizable diagnostic "gray zone" of cases, to which generalizations do not apply well. In such cases the patients must be considered individually. In the alcoholic patient who has experienced recurrent attacks of severe and prolonged upper abdominal pain, each attack requiring repeated doses of opiate for relief, and with markedly elevated values for serum amylase and lipase during a seizure, the diagnosis of chronic relapsing pancreatitis is on fairly safe ground. The same cannot be said of the diagnosis in the case of a nonalcoholic patient with atypical pain and normal or borderline values for serum or urinary enzymes. There are, obviously, shades of definiteness in this intermediate diagnostic group. When the sequelae or complications of pancreatitis are detectable, the diagnosis becomes more definite, as noted.

There is sometimes uncertainty as to how much reliance can be placed on the surgical findings. Again, these can be most definite and informative, as when severe hemorrhagic pancreatitis or extensive parenchymal or fat necrosis is found. The finding of pancreatic "tumor," with or without performance of biopsy, however, may leave room to suspect underlying carcinoma, and a surgical report of mild-to-moderate pancreatic enlargement or induration also has less diagnostic meaning. Even more confusion may follow the surgeon's report that the pancreas seemed normal; such an impression, particularly when operation is performed a few days or weeks after pain has subsided and early in the course of chronic pancreatitis, does not exclude that diagnosis.[21]

Most clinicians are now aware of the several conditions other than primary pancreatitis which may provoke increase in the values for serum amylase and lipase. Mumps, prior administration of opiates, intestinal obstruction, perforated peptic ulcer, peritonitis and renal insufficiency are potential diagnostic pitfalls in this connection.[20]

Recently, determination of the content of amylase

in the urine has been revived and employed more widely as a diagnostic tool in patients with active pancreatitis.[34] The available evidence suggests that the urinary excretion of amylase often remains high for days after the concentration in the serum has returned to normal. The observations of Gambill and my own limited experience with the urinary amylase test are in accord with this view. Since determination of the content of amylase in the urine can be performed on an accurately timed 2-hour specimen, the result is available within a few minutes, and the test is inexpensive and simple, it should prove useful in the diagnosis of pancreatitis.

Hereditary Pancreatitis

Since 1952 a number of interesting kindreds have been observed in multiple members of which pancreatitis has developed.[8,19,21] The first of these families was described by Comfort and Steinberg, who pointed out most of the essential clinical features. Since that time my associates and I have observed at least four other such kindreds, and both Jackson[27,28] and Doubilet have encountered a family. Apparently the condition is not so uncommon as might be supposed.

In its clinically recognizable form the condition probably is inherited as an autosomal dominant trait. Transmission, apparently in accordance with mendelian laws, justifies the designation of "hereditary" (rather than simply "familial") for this form of pancreatitis. Whether abortive or incomplete forms exist in some of the blood relatives, as happens in the case of cystic fibrosis, for example, is not known at present.

Hereditary pancreatitis makes its appearance early in life. The typical patient is a young adult, usually with a history of similar attacks recurrent since early childhood. Originally, females seemed more commonly affected than males but subsequent observations indicate that the incidence according to sex is approximately equal in the still-small population sample.

The hereditary form of pancreatitis clinically resembles the nonhereditary form of relapsing pancreatitis in most respects. Affected persons usually experience the same severe seizures of upper abdominal pain lasting for days at a time, necessitating repeated injections of opiate for relief, and frequently hospitalization for a week or more. Some attacks may be mild and evanescent, others severe and incapacitating. The same sequelae of diabetes mellitus, pancreatic calcifications and external pancreatic insufficiency may develop after sufficient destruction of the pancreatic parenchyma has occurred, and the complications of pseudocyst, abscess, gastrointestinal or retroperitoneal bleeding and addiction to opiates may occur also.

A few clinical features are peculiar to the hereditary type of pancreatitis. The principal difference from the nonhereditary disease, other than the familial involvement, is the early age at onset; hereditary pancreatitis is primarily a disease of children and young adult persons. Gallstones and alcoholic excesses have been encountered infrequently among persons with the hereditary disease. Interestingly, the calcific deposits in the pancreas in those with hereditary pancreatitis are mostly in the form of calculi in the larger pancreatic ducts, which fact probably has some significance, as yet undetermined.

It is likely that those with hereditary pancreatitis have inherited some predisposing abnormality, since the condition is transmitted in accordance with mendelian laws and since it becomes manifest so early in the lives of those affected. The nature of the inherited predisposing abnormality is not clear, although it is likely of a biochemical or metabolic character; in those examined at operation or necropsy to date we have not observed evidence of an anomalous arrangement of the pancreatic or bile ducts, nor of other anatomic abnormality. Microbiologic assays in some persons with hereditary pancreatitis, as well as in a few of their as yet seemingly nonpancreatitic blood relatives, have shown some abnormalities, chief of which is an amino-aciduria in which relatively large amounts of lysine are excreted.[19,22] That this amino-aciduria has any etiologic or pathogenetic significance in the development of pancreatitis in such persons is not established, however.

Pancreatitis and Hyperparathyroidism

In 1957 Jackson[26] and also Cope and associates described the clinical association of pancreatitis and hyperparathyroidism. The suggestion was made that the hyperparathyroid state in some way had given rise to the pancreatitis in these cases and a few previously recorded. The association of these two unusual diseases is interesting, not because large numbers of patients have been involved, but because (1) there is implicit in this association a cause-and-effect relationship, a provocative hint related to the pathogenesis of pancreatitis, and (2) for the clinician, a new diagnostic clue to either condition is suggested.

As indicated, the number of such patients described thus far is small—to the present, perhaps twenty-one.[6,10,13,19,25,28,31] However, only two[19,33] of the six

patients encountered thus far at the Mayo Clinic (four of them since 1958) have been reported upon, and apparently a similar situation obtains elsewhere.[9] In most of this group of twenty-five-odd cases one theme recurs with some regularity: upper abdominal pain develops, and a clinical diagnosis of pancreatitis is made. The content of calcium in the serum, determined in order to follow the course of the pancreatitis and with the anticipation of finding a low value, unexpectedly turns out to be high. The finding of persistent hypercalcemia suggests hyperparathyroidism, and eventually a parathyroid adenoma is removed.

In a number of such instances the pancreatitis is said to have abated after parathyroidectomy. This suggestive evidence and the remarkable familial involvement (two brothers and their mother) reported by Jackson and associates do support the idea that the hyperparathyroidism in some way has predisposed to recurrent pancreatitis in these patients. In most of the cases the duration of either of the two conditions apparently is not known; this is particularly true with respect to the hyperparathyroidism.

If hyperparathyroidism can lead to pancreatitis, what is the mechanism? One suggestion proposed is that the hypercalcemia favors formation of stones in the alkaline milieu of the pancreatic ducts, with resultant obstructive pancreatitis. Such an explanation might apply to those instances in which stones are found in the larger pancreatic ducts, but it is difficult to reconcile this hypothesis with the fact that no pancreatic calcifications have been noted in approximately half of the persons observed. Germaine to the matter is the recent work of Haverback and co-workers, showing that the addition *(in vitro)* of calcium ion to pancreatic juice until the concentration exceeds 7 milliequivalents per liter permits activation of trypsinogen by trypsin, a reaction postulated to be of importance in the pathogenesis of pancreatitis.* Also of some interest are the data obtained by Schilling and associates showing that both canine and human pancreatic tissue normally contains relatively high concentrations of calcium (compared with liver and muscle) and that the calcium content of inflamed canine and human pancreatic glands is markedly elevated. It should be observed, however, that a critical piece of evidence is still lacking; namely, the calcium content of juice from the pancreatic ducts of healthy persons and of patients with coexistent hyperparathyroidism and pancreatitis. The latter data should not be difficult to obtain if, at operation on such patients, the surgeons are alert to the opportunity presented.

The physician aware of the possible coexistence of hyperparathyroidism and pancreatitis, when confronted with either condition, will think of the other. In the patient with hyperparathyroidism and unexplained attacks of upper abdominal pain, the possibility of pancreatitis should come to mind. Conversely, the calcium content of the serum of each patient who has pancreatitis should be determined, not only to establish whether or not hypocalcemia is present, but also to bring evidence to bear on the possibility of hyperparathyroidism; it should be kept in mind that a tendency toward hypercalcemia may be masked temporarily if active pancreatitis is also present.

Pancreatitis and Hyperlipemia

This subject, reviewed recently,[1,19,30,36] will not be considered here in detail. It is appropriate to note, however, that occasionally patients with active pancreatitis are found to have turbid serum, which on analysis is found to contain high concentrations of lipids; also of interest is the occurrence of relapsing pancreatitis in some persons with familial hyperlipemia.

It is not known whether the hyperlipemia in such patients results from or provokes the pancreatitis, or whether both are perhaps consequences of some other metabolic derangement in the body. Experimental and clinical observations to date suggest that the concomitant occurrence of the two conditions is more than coincidental and probably is more frequent than has been realized. This fascinating relationship, inviting further study, doubtless holds important clues to the pathogenesis of some instances of pancreatitis.

Therapy

There are only a few guiding principles in the management of patients who have pancreatitis. One of these is general support of the patient, including relief of pain; another is to put the patient and the inflamed organ at rest; a third measure is removal of possible precipitating factors, to prevent future attacks, with consequent pancreatic destruction. It is obvious that the extent and character of the therapeutic measures will vary with the severity of the attack and with other circumstances in the individual patient. If the sequelae or complications of pancreatitis supervene, special treatment is in order.

The therapy of acute pancreatitis has been mentioned above. It is the consensus that acute pancreati-

*It may be noted that the work of Beck and associates questions the validity of this concept.

tis is best managed medically. Mild attacks may require little except rest in bed for a day or two and appropriate dietary limitation. Severe attacks may necessitate vigorous support in the form of the administration of blood, adequate doses of opiate for relief of pain (if nitroglycerin or other antispasmodic is unavailing), continuous gastric aspiration and parenteral replacement of water and electrolytes. Significant hypocalcemia calls for the intravenous administration of 10 ml. of a 10 per cent solution of calcium gluconate two or three times daily. If fever is present, one of the tetracycline antibiotic agents is given orally in doses of 500 mg. every six hours or intravenously every twelve hours to prevent secondary infection. A combination of 1,000,000 units of procaine penicillin and 1 gm. of streptomycin administered intramuscularly each day in divided doses seems equally satisfactory.

After the acute attack has subsided, an attempt is made to prevent further bouts of pancreatitis by advising the patient to avoid alcohol completely and permanently; to employ a bland diet, avoiding spices, large amounts of greasy foods and overloading of the stomach; and to obtain adequate rest and relaxation. Studies should be conducted a month or so after the acute seizure has subsided in order to exclude the presence of gallstones, hyperparathyroidism and persistent hyperlipemia. Cholecystectomy or, less often, removal of a hyperfunctioning parathyroid gland or adenoma may be indicated. The demonstration of persistent hyperlipemia invites trial of 1 gm. of nicotinic acid administered orally two or three times daily, or appropriate doses of triparanol (MER-29) or some other agent designed to bring the lipid content of the plasma to normal.

Late in the course of chronic pancreatitis, diabetes mellitus and external pancreatic insufficiency commonly are present. The diabetes calls for measures similar to those employed in the treatment of diabetes of the ordinary type; by extrapolation from experiments in animals with extirpation of the pancreas, severe diabetes resulting from destruction of the pancreatic islets should be largely refractory to the sulfonylurea compounds. Deficiency of external pancreatic secretion, with resultant steatorrhea and azotorrhea and attendant fecal losses of calcium and fat-soluble vitamins, can be controlled satisfactorily by administration of pancreatin or viokase tablets (each containing 0.3 gm. or 5 grains) in doses of 2 to 5 gm. with each meal, or one tablet to three tablets hourly when awake.[20,29]

The surgeon plays the major role in the treatment of severe and progressive chronic pancreatitis and its complications.[5,32,37,38] Many operations have been employed and none has been found entirely reliable. Choice of operation will depend on the circumstances in the individual case, as well as on the surgeon's experience and judgment at the time of operation. If gallstones are present, cholecystectomy and exploratory choledochostomy are indicated. At that time transduodenal sphincterotomy also may be carried out.

Internal or external biliary-drainage procedures have been followed by good results (prolonged periods of remission) in a half to two thirds of cases,[32] and distal pancreatectomy with retrograde pancreatojejunostomy has proved helpful in some cases in which there is obstruction of the pancreatic ducts in the head of the gland. Removal of calculi from the pancreatic ducts is accomplished when feasible. Total pancreatectomy rarely has been performed for intractable pancreatitis. Drainage of pancreatic abscesses and pseudocysts may be necessary. Splanchnicectomy has been followed by relief of pain for prolonged periods in some patients.

It is apparent that the treatment of pancreatitis is a combined medical and surgical endeavor, which must be individualized. In an unfortunate minority of cases all therapeutic efforts may fail to control the disease; a number of such patients eventually become demoralized, bankrupt and addicted to opiates. Complete rehabilitation then is indicated but often is impossible. In such cases the disease is truly malignant, though not neoplastic.

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"It's unwise to pay too much, but it's worse to pay too little. When you pay too much, you lose a little money—that is all. When you pay too little, you sometimes lose everything, because the thing you bought was incapable of doing the thing it was bought to do. The common law of business balance prohibits paying a little and getting a lot—it can't be done. If you deal with the lowest bidder, it is well to add something for the risk you run, and if you do that you will have enough to pay for something better."—JOHN RUSKIN (1819-1900).

Treatment of Arthritis with Guanido-Amino-Peptidase

A Preliminary Report

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ALTHOUGH the widely heralded ACTH, cortisone, and the many related steroids have done much to temporarily alleviate the symptoms of arthritis, this group of therapeutic agents is failing to fulfill the hope of a real cure. A high incidence of serious untoward reactions follows even recommended therapeutic dosage. Another drawback is the fact that when administration of steroids is stopped, the arthritic symptoms return, sometimes more severely than before treatment was initiated. The author, himself an arthritic (rheumatoid spondylitis), knows from his own personal experience, as well as from that of his patients, the true meaning of the consequences of false hope. But progress depends on utilizing the available information and adding to it the newer knowledge obtained from research.

The present report describes the results obtained in fifty arthritic patients with guanido-amino-peptidase, a guanidine-reducing enzyme.

Although some actions of enzymes have been known for many years both in medicine and in industry, the true significance of the important roles played by enzymes in health and disease are only now being established. In the field of arthritis, attention was called to the therapeutic value of specific enzymes by Blackberg,[1] one of my co-workers with guanido-amino-peptidase.

Working with adenosine-5-monophosphate, which is closely related to guanido-amino-peptidase, he demonstrated the important role played by this enzyme and many others in maintaining maximal functional efficiency of the body as a whole. After summarizing the known facts concerning the effectiveness of this enzyme in many diversified disturbances he stated:

> It helps us to understand how any disturbance resulting in a lack of AMP or other enzyme constituents may have a causal relationship with the many rheumatic disorders and directly or indirectly with other degenerative disease processes. . . . With each advance in the knowledge of cell chemistry and the structure and function of enzyme systems, we come closer to a definition of life and to a better understanding of the etiology, pathogenesis and treatment of disease. Replenishing the cells with the molecular components necessary for normal cellular activities is therefore the basis of this new approach to disease therapy and with it, the birth of a new age in medical science.

That guanidine may play a role in the etiology of some forms of arthritis has been proposed by several investigators.[2] A symposium by Krebs and Harris gives further evidence of the causal relationship between arthritis and enzyme imbalance:[3]

> Failure of an enzyme system to hydrolyze or "crack" food products sufficiently for their removal, will disrupt the normal functioning of these complex processes. More than likely, as an antecedent factor in arthritis, imbalance in an enzyme leaves cellular waste products insufficiently oxidized for proper handling by the kidneys or other excretory organs, thus admitting into the circulation toxic compounds that irritate the serous membranes of the body, particularly the extensively used joint membranes.

Procedure

Fifty patients, twenty men and thirty women, with various types of arthritis, who failed to respond to previous therapy were treated with guanido-amino-peptidase. They ranged in age from twenty-two years to seventy-five years. Diagnosis was made in accordance with the diagnostic standards of the American Rheumatism Society. They were classified as follows: rheu-

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matoid arthritis, 49 per cent; osteoarthritis, 37 per cent; mixed, 14 per cent.

Previous treatment varied and included salicylates, ACTH, cortisone, prednisone and other steroids, heat, diathermy and massage. Only patients who failed to benefit from previous treatment were included in this study.

The therapeutic agent being studied is guanido-amino-peptidase, an enzyme which acts on the potentially harmful guanidine and converts it to urea and ammonia, which are readily excreted or rendered harmless. Under normal conditions guanidine is metabolized, but in patients with rheumatoid arthritis there may be a disturbance either in the enzyme activity or other metabolic processes which may lead to an increase in guanidine. By the administration of guanido-amino-peptidase the guanidine is broken down to urea and ammonia and eliminated. This is not unlike many other diseases which are caused by impaired enzymatic activity and are therefore improved by restoring the needed enzyme. Gout, with its disturbed purine metabolism and accumulation of uric acid salts, is greatly benefited by any agent which helps eliminate the excess urates.

The guanido-amino-peptidase (Barthro) was administered intravenously in the form of an aqueous extract, buffered to the desired pH and activated for optimal enzymatic activity.* The dose of 5 cc. containing 2 Q units of active enzyme was injected intravenously every third day for six to twelve injections. One Q unit designates the enzymatic activity decomposing 1 mg. of a standardized substrate.

*Supplied in activated, standardized form under the trade name, Barthro, by Barry Laboratories, Detroit, Michigan.

Results

Because the patients included in this study were refractory to their previous therapy, their beneficial response to Barthro induced the author to prepare this preliminary report while additional studies are still in progress. Excellent results, with complete freedom of symptoms, occurred in 40 per cent of the patients treated. Good results, with return to pain-free activity —but persistence of irreparable tissue damage, occurred in 54 per cent. Poor results, with some diminution of pain but without restoration of normal function, occurred in 6 per cent. Although maximum doses were given for long periods, no toxicity or untoward reactions were observed in any of the patients treated.

Conclusion

Guanido-amino-peptidase was administered intravenously to fifty arthritic patients who failed to respond to previous therapy. Ninety-four per cent of the patients showed remission of symptoms and return to normal activities; 6 per cent showed a poor response although pain was relieved, and no untoward reactions or toxicity occurred in any of the patients.

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Prothrombin Synthesis in the Dog

Information was obtained on biosynthesis of prothrombin and how drugs such as coumadin and vitamin K_1 function at the cellular level. Flourescent anti-dog prothrombin was used to mark those dog liver cells containing prothrombin when prothrombin production was modified by drugs. Coincidental with sampling of the liver, blood was drawn for studies of circulating coagulation factors. It appears from these that normally liver parenchymal cells are engaged in cyclic asynchronous production of prothrombin. Studies of prothrombin-depleted dogs following coumadin treatment clearly show that the mechanism of action of this drug is to interfere directly with biosynthesis rather than to promote storage of prothrombin. Vitamin K_1 administered to such dogs promoted prothrombin synthesis.

A precise timing in the sequence of cellular and circulation events following vitamin K_1 treatment was found. First there was a lag phase while precursors were mobilized and sufficient quantities of prothrombin formed to be detected by the fluorescent antibody technique. Only a small increase in circulating prothrombin occurred over the next two and one-half hours, while more and more parenchymal cells were marked as actively engaged in prothrombin synthesis. During this period, the status of the circulating procoagulants as indicated by the one-stage assay returned to normal. The two and one-half- to four-hour period was one during which all of the liver parenchymal cells were stimulated to synchronous production of prothrombin with storage indicated by the most intense cellular fluorescence seen at any time. This was followed by a release period when cellular fluorescence decreased and circulating prothrombin increased to normal.

Vitamin K_1 given to normal dogs, also, promoted synchronous parenchymal cell activity with a small release of prothrombin to the circulation. It appears, however, that a regulatory mechanism exists which maintains the circulating prothrombin within limits by promoting either storage or release of prothrombin by liver parenchymal cells. (Supported in part by the Michigan Heart Association).—*Abstract of a paper presented by Gordon F. Anderson and Marion J. Barnhart of Wayne State University, before the Detroit Physiological Society, March 16, 1961.*

Pulsion Diverticulae of the Esophagus

A Report of Fifteen Cases Repaired by a Single-Stage Procedure

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OUR REPORT includes a detailed account of our technique, results and observations. The salient features of this interesting condition and the evolution of its surgical correction are more abundant in the literature. We refer the reader to the detailed accounts of Harrington,[1] Sweet,[2] and McNeeley and Glassman.[3] The first descriptions of pharyngoesophageal diverticulae is generally credited to Ludlow in 1764, Bell in 1816, and Meckel in 1832.[4] However, it was not until 1877 that this defect became well known through the classic description of Zinker.[5] So remarkable was his presentation that this diverticulum is sometimes referred to as Zinker's Pouch. These early writers were joined by Goldman,[6] who described the original two-stage operation, C. H. Mayo,[7] E. Starr Judd,[8] and F. H. Leahy,[9] all of whom contributed greatly to the refinements of the two-stage procedure. The original interest in the two-stage procedure was stimulated by an effort to reduce the high incidence of postoperative mediastinitis, pneumonia and fistulae with which the earlier one-stage procedure was cursed. The mortality rate of early one-stage procedures was considerable and the two-stage operation did much to overcome this. The problems and complications that attended the single-stage procedure when first done were largely due to improper techniques and inattention to certain basic principles. The use of ponderous catgut sutures plus the cauterization, carbolization and inversion of the stump played prominent roles in the number of abscesses, fistulae, and the occasional cases of esophageal stenosis that were seen. Little heed was paid to the segmental blood supply of the esophagus, and the diligent care which must be exercised to avoid tissue trauma in esophageal work was not observed.



Author

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Generally speaking, diverticuli of the esophagus are usually divided into three main groupings: pulsion, traction, and super-diaphragmatic. Pulsion diverticuli, those with which we are concerned, are usually situated in the hypopharynx at the pharyngo-esophageal junction. Traction diverticuli are those usually confined to the mid-portion of the esophagus and are the result of inflammatory attachment to the esophagus by adjacent carinal nodes. The exact classification of super-diaphragmatic diverticuli has not been accurately determined. Actually, as Harrington[1] has stated, the term esophageal diverticulum is anatomically incorrect for two reasons. First, the diverticulum rarely is invested with a muscle coat and should therefore be termed more properly as saculation. Secondly, the mucosal herniation actually occurs through the muscle fibers of the pharynx and not the esophagus (Fig. 1). However, time, convenience, and tradition have firmly implanted the misnomer in the medical literature of today. Satisfactory proof for the acceptance of any one factor in the etiology of diverticuli has yet to be presented. Coburn[10] ascribes to the theory of congenital influences in describing the presence of a pharyngeal pouch in pigs and reports cases in a two-year-old and in an eight-year-old child. Congenital mal-developments of the hypopharynx, the esophageal pouch or the crico pharyngeal muscle would thus be predisposing factors to these pulsion diverticuli. King,[11] conversely, attributes the condition to the anatomic relationships of the cervical vertebrae to the fascia and extrinsic muscles of the esophagus. His detailed pharyngeal and esophageal anatomy, as they occur about the maturely developed larynx, and the relation to the cervical spine, plus his observations on the act of swallowing and the exertion of pressure on these anatomic deficiencies are convincing. We wish merely to state that in our relatively

small series, all of the patients have had swallowing difficulties attendant with upper dentures and a history of improper mastication.

The average age of the patients in our series has been sixty-three years. The youngest patient was forty-eight, the oldest eighty-three. The symptoms are essentially of six months to four years in duration. These include: dysphagia found in all fifteen patients, orthopnoea in six, hoarseness in seven, weight loss in twelve. All of the lesions were demonstrated by fluoroscopic x-ray examination with opaque media. In each case the lesion was endoscopically inspected, the diverticulum being visualized, so that the diameter of the orifice could be determined. The diverticuli were aspirated to determine bacteriologic content and also rid them of secretion prior to surgical extirpation.

Preoperative Preparation

The surgical preparation consists of: 1. The correction of dehydration and the alterations of body chemistry resulting from the near starvation diets. On occasion this has proven a difficult task. The use of the appropriate intravenous fluids or the feeding of a high caloric diet by a nasal gastric tube is sometimes necessary. If difficulty is encountered in the passage of the nasal tube to be used for feeding, it may be inserted at the initial esophagoscopy or it may be inserted by passing it down a string which the patient has previously swallowed. 2. An anti-bacteriologic program consisting of streptomycin and penicillin is given twice a day for two days prior to surgery. 3. Endoscopic examination of the true esophageal lumen and the diverticulum take-off with dilatation of the main esophageal lumen thus minimizes the danger of pressure rupture at the site of the closure of the pharynx following surgical repair. 4. As hoarseness is such a common complaint in this disease, all of the patients are subjected to direct laryngoscopic examination to rule out any co-existing pathology of the cord structures.

Surgical Technique

The operation was performed in all cases using gas, oxygen, and ether endotracheal positive pressure anesthesia. The results of this technique in this series was satisfactory. With the patient in the reverse Trendelenburg position, and the head extended, a small pillow is placed beneath the shoulder of the operative side, the head is turned toward the other side. Unless the P.A. film demonstrates the sac to be to the right of the midline, the left sternocleidomastoid is used as the line of incision. The incision is made parallel to this muscle fold, from the level of the prominence of the thyroid cartilage down to approximately 2 cm. above the clavicle. The usual incision is 7 to 8 cm. in length. The platysma is cut across in the line of incision and the superficial layers of the deep cervical



Fig. 1. Advanced diverticulum with a broad base. Case 8.

fascia are opened. This incision frees the sternocleidomastoid muscle so that it may be retracted laterally and pulls medially the sternothyroid and the inner belly of the omohyoid and thus exposes the carotid sheath. Dissection between the carotid sheath and the thyroid gland is readily accomplished by ligation of the middle thyroid veins. Retraction of the gland, medially, and of the carotid sheath laterally, exposes the esophageal bed. Remnants of the buccopharyngeal fascia bind the esophagus to the paravetebral fascia but simple blunt dissection readily frees the esophageal pharyngo junction and the base of the inferior constrictors, the cricoidius and the muscles that contribute to the sac of the diverticulum, at the upper end of the esophagus. The use of Green and Brewster retractors greatly aid the exposure so that the anatomic site of herniation can readily be visualized. Two points of importance in the isolation of and the resection of the sac are (1) accurate definition of the sac neck, and (2) preservation of two separate coats, the muscularis and the mucosa. Although the wall of the sac may have suffered multiple attacks of inflammatory change, leaving its walls thick and distorted, it is usually possible to outline the ruptured muscle layers as a fringed collar extending 1 to 1½ cm. onto the sac wall. This should be dissected free

with particular care given to hemostasis. If they are not completely separated, they may form a ridge over which a new diverticulum may form. The esophageal submucosal venous plexus may be troublesome in the

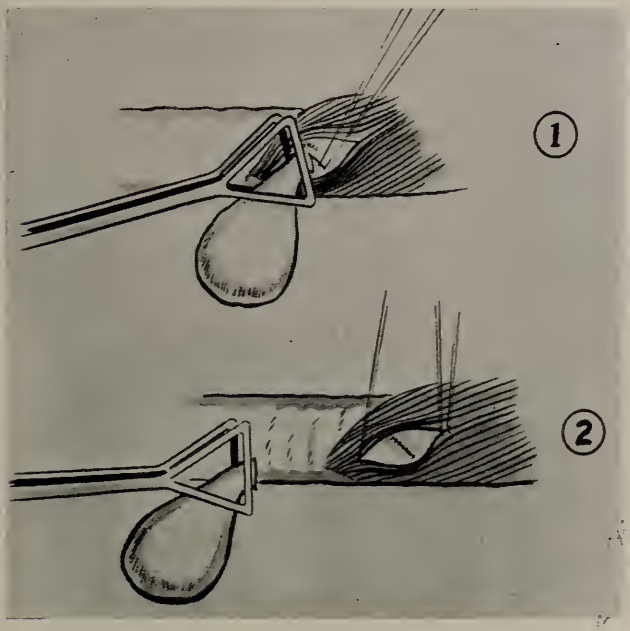


Fig. 2. Technique of sac resection with a two-angle closure of mucosa and muscularis.

presence of inflammation. It may be well, as Coburn suggests, to ligate this plexus early to avoid bleeding since even a small hematoma impairs the viability of the suture line. Having secured the exact mucosal neck of the sac and a free separate muscular layer, it is important to divide the neck of the sac flush with the cricoid muscle to prevent cutting on a bias. Guide sutures are secured in the muscular corners and a Duval lung clamp is placed across the sac's neck so that its forward jaw is parallel to the line of incision. For the mucosal approximation 0000 silk is used, cutting and sewing across the base with individual, interrupted sutures. No effort is made to invert the suture knot as is suggested by Sweet. The muscular layer is closed separately with 0000 silk. A small Penrose drain is left in the superficial portion of the wound and the fascial layers are closed with silk. The realignment of the muscularis of the esophagus obviously can only be in the plane of the constrictor fibers. However, the realignment or the suture line of the mucosa could be made and swung in almost any direction. The advantages of the method are: 1. There is no suture ridge or dimple for the start of a new sac. 2. The two angle closure strengthens the posterior pharyngeal wall as cross grained plywood adds strength to its respective thickness (Fig. 2).

Postoperative Care

The patients are returned to bed in a sitting position. They are allowed to sit on the side of the bed or be up on the first day. The Levine nasal tube is left in place for the first twenty-four hours to rid the gastrointestinal tract of gas and to prevent emesis. Fluid replacement is given by the intravenous route. On the morning of the third day, water by mouth is begun, one-half ounce per hour given in small sips; in six hours this quantity is increased to one ounce an hour, stress being laid on small sips; and at the end of the second six-hour period, water, in small sips, is given freely, by mouth. On the fourth postoperative day a clear liquid diet is prescribed and with the aid of our dietetic staff a progressive semi-soft diet for the next four days is given. Since Terramycin has been available, we have used it in quantities of six drops q two hours during the first and second postoperative days. This medication is dropped on the back of the tongue and we feel it is of value in controlling oral hygiene.

Results

In our fifteen cases there have been no deaths. Fourteen of the wounds healed by first intention, and in one case there was a small salivary fistula that closed spontaneously on the fifth postoperative day. All of the fifteen patients have been followed for over two years. The oldest follow-up is fifty-four months in duration. There have been no recurrences. All of the patients have been re-examined with barium swallow. In the patient who had the salivary fistula, we are unable, on fluoroscopic examination with Rugar, to demonstrate the site of this fistula. The swallowing mechanism is smooth and there has been no tendency to new pouch formation. One patient in the series had persistent swallowing difficulties for a four-month period. Direct esophageal examination by a Negus scope and dilatation of the true esophageal lumen apparently corrected this condition. All of the patients have been cautioned as to their eating habits. Ill fitting dentures have been replaced and the thoroughness of mastication has been stressed.

Conclusions

With the aid of antibiotics, accurate preoperative evaluation and preparation, exacting surgical technique and persistent postoperative care, we feel that the single stage resection of pulsion diverticulum of the esophagus has been reduced to a surgical exercise the risk of which is minimal, its complications few, and its results excellent.

(References on Page 613)

Quinine Idiosyncracy and Optic Atrophy

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IT IS a well-established clinical fact that certain individuals may suddenly become deaf and blind following the ingestion of quinine, even in small doses. The following case report illustrates that an idiosyncracy to quinine should be borne in mind as a cause of sudden bilateral blindness.

A nineteen-year-old white girl was admitted as an emergency to Wyandotte General Hospital on April 27, 1956, with the complaint of ringing in the ears and blindness of twenty-four hours' duration. Inquiry revealed that the patient had taken "several dozen quinine-cold-tablets" over the previous five days in an attempt to induce a miscarriage.

Physical examination revealed a frail, delicate girl, looking younger than her stated age. The pupils were fixed, widely dilated and did not react to light or to accommodation. The hearing was markedly impaired, and she could hear only the shouted voice. The remainder of the physical examination, including the neurological, gave negative findings. Spinal fluid examination was negative with no evidence of increased cerebrospinal fluid pressure. The initial impression was: bilateral optic neuritis and tinnitus, secondary to quinine poisoning.

The following day, when the patient was examined by Dr. J. M. LaBerge, she would not admit to light perception. The pupils were widely dilated and fixed. The vitreous was clear; the margins of the optic papilla were blurred, and the retina edematous. The retinal arterioles were spastic, and the macula stood out in bold relief, like the "cherry-red spot" seen after a central retinal artery occlusion.

After forty-eight hours, the tinnitus cleared, but the ocular fundus picture remained unchanged. On the tenth day, the patient admitted to light perception and showed nystagmus when bright light was flashed on the macula. On the twelfth day, the patient could count fingers at 2 feet, and the retinal vasospasm was alleviated slightly. (The essentials of treatment in hospital consisted of vasodilators and sedation.)

Following discharge from the hospital, the vision improved very little. On August 18, 1956, the patient was given Prednisolone orally and Vitamin B_{12} intramuscularly; however, after six weeks' therapy, the vision could be improved to light perception only in the right eye and counting fingers at four feet in the left eye, improving to 20/300 "at times" with pinhole.

On examination June 20, 1958, the visual acuity had not changed. The right eye was exotropic approximately 20 prism diopters, and the patient could not fixate well with either eye. The pupils were widely dilated, but did react sluggishly to light and to accommodation. On fundoscopic examination, the optic discs were pale and atrophic. The arterioles were attenuated, the veins showed sheathing; the retina was thinned and atrophic; a pigment clump was seen in the macula of the right eye. The visual fields were difficult to evaluate. In the right eye, the patient could detect a moving light nasally 5 degrees, inferiorly and temporally 10 degrees, and superiorly 15 degrees. In the left eye, she could detect the light 20 degrees nasally, superiorly and inferiorly, and 50 degrees temporally.

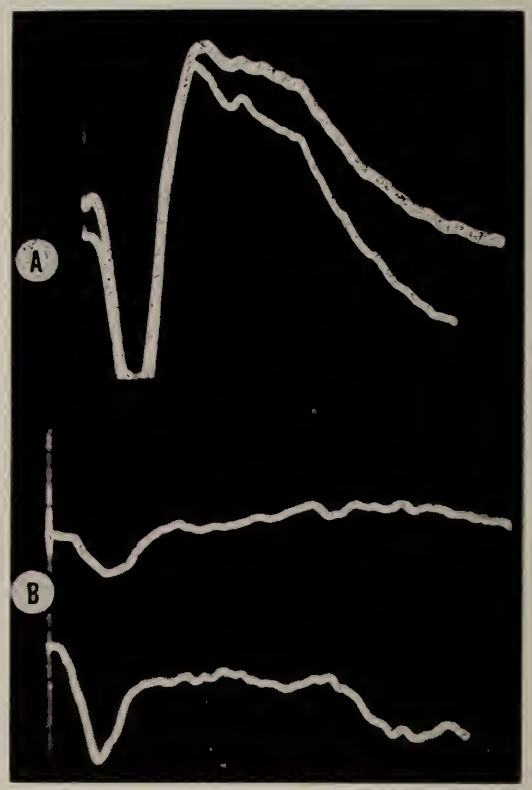


Fig. 1. Electroretinogram records. The upper tracing (a) is the response obtained in a "normal" eye; the lower tracing (b) is the record obtained following quinine optic atrophy.

An electroretinographic examination was carried out by Dr. A. D. Ruedemann, Jr., on July 25, 1958, at the Kresge Eye Institute. The ERG analysis revealed "a reduction in response to all light stimuli for both eyes. The highest b-wave amplitude for maximal intensity stimulus is only 88 microvolts for the right eye and 61 microvolts for the left eye. The normal range is 450 to 600 microvolts." (Fig. 1).

The patient's hearing, including audiogram study, was normal, in June, 1958.

Discussion and Comments

Proprietary medicines are taken for granted as "safe" drugs. Occasionally, an unduly sensitive individual reacts severely to these medicines, and the question again arises, "What are safe drugs?"

Quinine optic atrophy is a well-established clinical entity.[1] In years past, when quinine was a common remedy, the cases of ocular toxicity were widely reported. Dosages as low as 1 grain can produce visual symptoms in susceptible individuals.[2] The recently reported cases are sporadic, but dramatic.[3,4,5,6]

The toxic visual symptoms are of sudden onset, and bilateral. The effects range from the severe cases which display complete blindness and widely dilated, fixed pupils, to the mild cases which have slight amblyopia and contraction of the peripheral visual fileds. The prognosis is variable; some cases recover in hours, others require weeks. But most cases usually show a permanent contraction of the peripheral visual fields.

The pathogenesis of quinine visual toxicity is still not definitely known. Two theories have been proposed:

1. Direct toxicity on the ganglion cells in the retina
2. Retinal arteriolar vasoconstriction

Probably both factors play a role in the disease. Caminero[7] has suggested that "sensitized" individuals may have a delayed urinary excretion of quinine and thus become toxic.

Treatment of quinine amblyopia is still unsatisfactory. The following have been used, with limited success:

1. Vasodilators (e.g., Amyl nitrite, Priscolene®)
2. Paracentesis of the anterior chamber of the eye. (To maintain vasodilatation by way of hypotony)
3. ACTH[8]
4. B-Vitamins (e.g., Triamine, Nicotinamide,[9] B_{12})
5. Procaine injection of the superior cervical sympathetic ganglion[10]
6. Iodides[11]

Summary

A case report of toxic amblyopia due to quinine is presented. The severe and probably permanent visual impairment should caution the indiscriminate use of quinine in medicines readily available to the public without prescription.

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Trends in the Future of Private Practice

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ALL MAJOR ELEMENTS of medical care in the voluntary sector, i.e., hospitals and allied institutions, physicians, dentists and drugs, are under close scrutiny today. The private practice of medicine is experiencing increasing internal and external pressures which are reshaping its traditional forms. The overall situation is such that the quality of key decisions made in the next decade will determine whether the future practice of medicine is private or otherwise.

The purposes of this paper will be to examine the internal and external forces molding private practice, to view the concept of "privacy" in an historical setting, to identify the essential issues and to speculate on what all of this means to the practicing physician.

Internal Forces

The shape of private practice at any given point in time is determined by the product of internal and external forces, some acting in combination, others acting to neutralize one another. The ascendancy of any given set of formal or informal programs or developments upsets the equilibrium and quickly establishes a new set of relationships. It is a situation in which peripheral, hard to control, or hard to anticipate pressures can be determining, or initiative can carry the day. Because initiative is fundamental it behooves those supporting the concept of private practice to study and to try to understand the complexities and responsibilities of practice while the setting is still fluid. Initiative based solely on highly subjective outbursts is apt to be ineffective or even worse.

What are some important internal forces? Two stand out, (1) the growing complexity of medical science and (2) the supply of qualified practitioners.

Medical science seems to be growing at almost a geometric rate. This can be seen by controlling on diagnosis, age and sex and comparing the number and types of services rendered to patients in hospitals in 1958 as compared to 1938 or some earlier date.[1] It can be seen by a simple delineation of new advances in surgery, diagnosis or rehabilitation. As a direct result the art of medicine has become more complex. The challenge of successful application of basic insights has grown.

One outgrowth of the proliferation of medical science has been specialization. In 1931, 17.9 per cent of active, non-Federal, private practice physicians had a full time specialty, in 1959, 45.1 per cent did.[2] Over this time period, it became increasingly necessary to focus interest and practice in order to achieve sufficient quality and to rely on the consultation or referral help of other physicians in order to embrace family health care needs. It became true in and out of the hospital. The number of specialty boards grew from four in 1934 to nineteen in 1959.

Even within specialties, the flowering of medical science made it less and less possible for the individual practitioner to work alone. For many procedures, he needed essentially untransportable nurse, technician, peer and equipment help. Some procedures became possible in the office which were difficult or implausible at home, and many more became practicable only within the hospital. The rising percentage of office visits compared to home visits is a matter of record. The increasing use of the hospital is also evident. Between 1931 and 1958, the number of patient days of hospital use in general and special hospitals per 1,000 population rose from approximately 900 to 1,300.[3] During this time, not only the beds were used more actively, the emergency rooms and out-patient facilities also experienced greater traffic. The nature of the surgery or the tools needed to do a satisfactory job given the new state of knowledge often required it. Some of the tools, such as high voltage radiation or EEG, involved heavy capital investments making duplication at the sub-hospital level impossible and correspondingly, centralization (even among hospitals for some tools) necessary. The complexity of the work also demanded the centralization of manpower such as technicians for

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the sake of adequate training, supervision and control. As accuracy of test results became more important, the office was less able to match the hospital.

Most importantly, the forces of specialization and centralization led to the need for co-ordination and organization. Quality and economy of care as defensible objectives drew the solo practitioner into the orbit of the institution. Within this orbit, the physician became subjected to the requisites of group action at no little expense to his personal prejudices.

A second, important internal force is the availability of health manpower. The number of non-Federal physicians in private practice per 100,000 civilian population dropped from 108.4 in 1931 to 92.1 in 1959.[2] In 1959, the geographical distribution of the physicians in medical practice was very uneven. Considering all non-Federal, active physicians there was a range of from 95.9 per 100,000 civilians in the South to 154.4 per 100,000 civilians in the Northeast. In the greater metropolitan areas the rate was 158.4, in the isolated rural areas it was 47.4 with a steady progression in between. The difference is attributable largely to the distribution of full time specialists and hospital practitioners.[2] Physicians, particularly the full time specialists and house staff, tend to concentrate in densely populated, high per capita income, culturally rich areas.

The scarcity factor is difficult to assay. A declining ratio of physicians to population, even with the amplifying effect of new therapies and paramedical help, seems logically undesirable. In the absence of studies of physician supply based on a cross section study of population needs proving otherwise, the inference of a shortage is likely to persist. If a shortage does exist, one must speculate on the reasons why. Perhaps competing and newly emerging professions are alternately more attractive. Perhaps it is related to the fact that it is very expensive for a physician to get established today. Certainly, training periods are longer (even the general practitioners are now talking of a two year internship) and the investment in staff, equipment and rental in a busy office exceeds previous years.

The problems of supply and distribution tempt public action. If both persist, it is likely that government subsidy of medical schools and medical students will become a reality. Government money is rarely spent without a pattern in mind. And any pattern will probably contain elements of organization. Scarcity, *per se*, implies also that the drift from the home visit to use of the hospital will continue. It is demonstrably easier to see congregated than geographically disparate patients. Even the high expense of training has implications. A newly trained man with exhausted resources is apt to be interested in at least a partnership, possibly a group. If his training has been long enough, he may feel uncomfortable in the absence of formal allies even at the ambulatory level.

In similar and dissimilar ways, both the demands of medical science and the facts of medical manpower are confronting the private practitioner with the necessity of further organization and institutionalization.

External Forces

Several external forces impinge upon private practice. Some are more peripheral than others. Some are arbitrarily classified as external which might be called internal, but the dividing line is not a point at issue. Some of the more important forces are the following: large markets, costs, money volume, prepayment and insurance and selected qualitative considerations. Each is discussed briefly in turn.

Large Markets.—The market environment involving medical care has undergone a significant change in recent years and it promises to change further in the same direction. In a general sense, we see people moving from the farms and smaller towns to the metropolitan areas. Fewer and fewer people remain in their communities of birth. Regional differences and loyalties are being dissolved. In a residential sense, consolidation and bigness are becoming factors.

Organized labor has grown into manhood; the percentage of the total labor force in organized labor has almost doubled since 1920 with a noticeable tapering off of late. Several unions have developed large nationwide memberships and appreciable purchasing power or influence. A related growth has been that of large industry. Today a large percentage of the labor force works for industries and services doing business or with plants in more than one state.

Government has also grown markedly in the past few decades and it is still growing in response to such pressures as population increases, urbanization and industrialization. As the population has coalesced, the government has acted to make the internal forces bearable and to protect the individual against the directed interests of large groups. The growth has been stimulated also by such worthy objectives as national defense, highway construction, education and stabilization of the economy. The growth has taken

place at all levels—federal, state and local. It is highly likely that the growth will continue at a slower pace in the future involving greater and greater cooperation among all three levels with the Federal government playing a major role because of its superior money resources and its better developed administrative machinery.

Not only the size of market groups has changed. There has been a major change in character as well. The age composition of the population is in a state of change. The median age is rising and at the same time the population is growing older and younger. Mortality and morbidity patterns have changed. New savings in life are increasingly dependent on major victories against the diseases of middle and old age—for example, heart disease and cancer. There has been a remarkable increase in the average earnings per individual worker. He earns approximately three times today as much as his counterpart in 1900 after discounting the change in price level. Once more the wealth is more widely distributed. There is significantly wider car, home, insurance, etc., ownership today than even ten years ago. There has been an increase in the amount of schooling in most states.* People are becoming more interested in and better able to appreciate medical problems through more frequent exposure to doctors and to an increasing number of articles about health in popular and semi-popular media. They are more knowledgeable about medical care than ever before and more articulate about their wants. Social ideals have changed. The concept has grown that industry should protect the worker against the common hazards of life, through workmen's compensation, OASI, unemployment insurance, life insurance and health insurance. The courts have reflected the change in putting more emphasis on individual rather than property rights. Health is now often perceived or spoken of as a basic necessity ranking with food, clothing and shelter. There is no longer a question of whether people get it—only how. And in general, a preference has grown among most consumers for credit and time payments and for insurance, influenced originally perhaps by the withholding tax.

In summary.—The new market features large groups with impressive purchasing power willing to spend more on health as more and more of the necessities of life fall within their purchasing power, thoroughly conditioned to time payments and insurance, more articulate and specific about their perceived needs, standing for less and less regional contrast in either coverage or quality of care and tending to look upon good health as a necessity given the effectiveness of today's medical armamentarium.

Channeling the above general prejudices are four major groups: (1) government, (2) labor, (3) industry, and (4) prepayment and insurance. Among legislators at the federal and state levels, there is currently more interest in demand than need. Unable to get consistent testimony on need from professionals and interested always in constituent support, it was inevitable that the shift take place. The modern legislator holds the physician in less awe and he is more apt to support formalized action than he was as one result. Labor, in general, is desirous of including a major share of the medical care dollar under prepayment or insurance and through collective bargaining shift as much of the cost as possible to management. Management faced with the inevitability of paying more of the premium costs is beginning to share with labor a concern over overt controls so that concrete evidence is available that the money is well spent. This is particularly true in highly competitive lines. Prepayment and insurance stand between doctors and hospitals on one hand and consumer groups on the other uncertain about whether to rely sympathetically on professional solutions to problems or to exert some muscle from the outside in behalf of the consumer.

Rises in Medical Care Costs.—Between 1947-49 (base of 100) and 1959, the Consumer Price Index for all items increased 25 per cent; medical care as one major grouping increased 51 per cent, twice as much. Only transportation as a major grouping came close (46 per cent). All other major groupings increased less than 32 per cent. A breakdown of the medical care grouping reveals that the index for hospital room rates increased (107 per cent) over twice as much as general practitioner fees (44 per cent), about three times dentists' fees (34 per cent), over four times as much as surgical fees (25 per cent), and five times as much as prescriptions and drugs (21 per cent).

The peaking of the hospital cannot be passed off lightly by the private practitioners. Patients are not admitted, treated or discharged from creditable hos-

*In 1947, 42.3 per cent of the civilian noninstitutional population five to thirty-four years of age was enrolled in school. In 1959, the per cent was 55.5. Between 1946 and 1959, the total expenditure per pupil in daily attendance increased approximately 152 per cent in current dollars.

pitals without the signature of a physician. The high costs affirm the previously made point that the hospital is being used more actively. The fact that it is used without payment of rent or overhead by the physician, in most instances, behooves the physician to use it well. It should be added that the hospital is particularly vulnerable to inflation involving as it does many services that cannot be replaced by machines or formalized into rigid routines.

Large Volume of Money Spent on Medical Care.—In 1959, approximately $18.3 billion was spent on medical care exclusive of government expenditures on care, public health, public welfare, research and education. Adding government expenditures would push the total well over $20 billion. The amount of money spent by the public ranged between 4.0 per cent in 1948 and 5.4 per cent in 1959 of the public's disposable personal income, an increase of 35 per cent.[4] Such large sums for such an important purpose will not be spent without public interest in the future.

Visibility of Rising Costs.—Since the early 1930's, an increasing proportion of public medical care expenditures have been made through prepayment and insurance. This is particularly true of in-hospital doctor and hospital expenses. As a result, increases in some major costs are more quickly reflected in higher premiums or lower coverage and readily evident to many rather than the few becoming ill. Doctor's office, post-acute facility, drug and dental expenses are presently covered only minimally, but their inclusion in greater part at least seems only a matter of time. Cost changes, as a result, will become even more visible. Between 1948 and 1958, total accident and health premiums increased approximately 450 per cent; in 1958, they totaled almost $6 billion.

Allegations of Faulty Practice.—An active concern over quality of care has grown recently related to several factors. Greater sophistication among consumers has already been mentioned. In addition, there has been an increasing number of disturbing allegations of faulty practice. Some are rooted in rumor and exaggerated, secondhand accounts of individual experiences. Others, however, stem from specific studies.[5-8] Qualified investigators have revealed difficult to account for variations in practice, involving specific operations such as hysterectomies, related to the existence or absence of insurance or prepayment, and related to the organization of practice. The private practitioner will have to face up to these allegations in the future prepared with facts and figures of his own and prepared to change his ways where indicated.

Problem of Imbalance.—Among other external forces which might be mentioned, there has developed a fairly widespread concern with the balance of the private practice of medicine. In certain respects, facilities and programs seem overdeveloped, at least in some areas. The number of hospital beds required for general, short-term, and acute cases have more than kept pace with the population, and admissions per thousand population to these beds have risen 25 per cent between 1946 and 1959. At the same time, there has been a growing shortage of facilities and programs for preventive, post-acute and rehabilitative cases. Similarly, insurance and prepayment coverage have experienced an uneven growth. There is concern with over-insurance among a few people and lack of coverage for others, such as the aged, disabled and chronically ill. Some services are covered to the extent that misuse is suspected, and other services, for example, office practice or nursing homes, are covered only rarely.

The net effect of all these and other developments has been a growing interest in controls on the part of key consumer groups. Controls of all types are now discussed—moral, professional, financial and legal. The climate differs from the old days when there were unorganized, relatively uncritical patients, and when health issues were free of the strategems of collective bargaining and political enterprise.

Historical Setting

In the realm of medical care, the forces of centralization of authority, organization and institutionalization have been felt around the world. As is often stated, the United States is one of a few countries where private practice, as we know it, is so widespread. Within the United States, we can see these same forces affecting trades other than medicine. The professions of law and accounting have been affected. Even the basic scientist is now usually a part of a well-integrated whole, and industry itself is more highly organized and co-ordinated.

The United States differs from other countries in many significant ways, the experience of other countries regarding ownership may or may not be relevant. But the phenomena causing other segments of our economy to become institutionalized are acting also on medicine. Medical care, in fact, is particu-

larly vulnerable because of its intrinsic worth to the community. By looking back, the private practitioner can gain some appreciation that what is happening to him is not unique, some of it is the inevitable precipitate of basic changes in our economy and society.

The Problem

The problem facing private practice, in fact the whole voluntary movement, is fourfold. It is, in part, the classical problem of how to deal with high costs of essentials in a competitive, free enterprise economy. In part, it is a conflict between the planner, who distrusts the unpredictability of relatively free interaction and the element of chance implied in the absence of planned controls—and the entrepreneur. In part, it is the age-old battle over privilege between the professional purveyor (in many ways similar to the entrepreneur) and the consumer. Is the number of doctors needed a medical or a community decision? And, in part, it is the somewhat abrasive touching of two active worlds. On one hand is the broad environment where health is discussed incidental to other considerations (for example, raising take-home pay), where health is likely to be perceived only as a means to other ends. And on the other hand is the realm of service where what happens regarding prerogatives is of paramount importance—where health tends to become an end in itself and where ethics as well as practicable reasons are likely to grow in support of what is perceived to be right. The problem is subtly hidden at points, and it is often rationalized courageously, but the main elements are becoming more evident.

What Does This All Mean to Private Practice?

Although 28.9 per cent[9] of active physicians were on salary in the United States in 1959 working in government, hospitals, industry, teaching and research, the creed of medicine is still competition and individualism. This creed is sustained by the widely espoused psychology of the doctor-patient relationship, the feeling of independence growing out of the many years required to become a licensed practitioner and among other factors the relative shortage of physicians. The physician, in treating patients, becomes accustomed to making decisions and giving directions often without review or censure.

The creed is being subjected to stress. Better educated patients are beginning to question physicians in an attempt to understand the "whys" and to have some hand in helping themselves. Several professions now require many years of training and education leading to prestigeful positions. And among other developments, the clinical decisions of physicians are being tested by such mechanisms as medical audits and tissue committees, and their financial decisions are being questioned by the public. The change has been rapid in cultural eons.

The reaction of the physician to the changes in medical science, social orientation and organization has been in part defensive. Physicians refer frequently to the time when fees were set more on a paternalistic basis and largely unquestioned, and when the physician was a community in himself. A strong tendency exists to protect the autonomy and prerogatives of the physician by the physician through legal, economic, administrative and social means. The defense is interpreted by some as an anti-social, reactionary effort and by others more charitably as the adjustments of a profession to the inevitable consequences of institutionalization and centralization.

The concern of physicians about self-determination is expressed in various ways. At the local level, one sees efforts on the parts of physicians to get representation on boards of trustees of hospitals, to obtain the services of sympathetic M.D. administrators, and to resist organization beyond a certain point, saying that quality is too intangible to measure (medicine is an art). At the state level, one sees efforts to pass corporate practice of medicine legislation to protect the interests of the full-time specialists in the hospital (radiologist, pathologist, anesthesiologist and psychiatrist), to maintain physician control of Blue Shield and to keep the formulation of fee schedules within the society. At the national level, one finds organized lobbying against compulsory health insurance bills, and other official stands, most of which are highly conservative. At all three levels, local, state and national, organized medicine is concerning itself more and more with economic matters.

As much as, or perhaps more than, any profession, medicine has attempted to control its own ranks. The emphasis has been largely on a professional or moral plane and on quality rather than costs. The American Medical Association has made a distinct and successful effort to upgrade medical education. Today, only Grade A medical schools exist in the United States. In the early 1900's, this was not the case. Some nineteen specialty boards have been created by physicians to encourage and pass on extended training beyond medical school. Foreign medical student graduates are now screened by the

Educational Conference of Foreign Medical Graduates. And postgraduate educational programs are widely offered by such groups as the American College of Physicians and American College of Surgeons.

Economic controls *per se* have been minimal. State and local medical societies have concerned themselves with gross violations of charging practices, have helped develop fee schedules for the lower and middle income groups, and have helped to promote use committees in hospitals, but the leadership has not been aggressive or consistently well organized.

Given the environmental forces acting on private practice and the current posture of physicians, what are the implications—what does it all mean?

It means, purely and simply, that the scene is shifting and doctors must learn quickly to accept their new social and economic as well as clinical responsibilities. The changes taking place should not all be viewed as interloping or unrightful interference. Some must be accepted, others must be guided by affirmative action.

It should be clear that the physician has always had social and economic responsibilities. This is not a new motion. Not too many years ago, the physician wisely charged patient A less and patient B more, he gave a great deal of psychological support to the family, he harangued the druggist to produce high quality prescriptions, and he taught a wide variety of assistants, often informally.

The times have changed and so must the techniques. The physician must become concerned with the quality of the hospital, as he is with the quality of his office practice. He must be concerned about making prepayment and insurance work. They are here to stay, representing the patient's new form of payment. They give him less opportunity for discriminatory pricing, but they are as important to understand as patient A and patient B. He must have a philosophy toward the aging and aged as he once had about "Grandmother Jones." He must be articulate about the larger community in the same spirit that he could actively discuss familiar names and faces. And he must learn to use group action techniques, such as organization, administration, control and planning, to supplement the force of his own personality.

More Specifically

More specifically, what might the physician do? He should become more active in several ways.

Office—Here there is no substitute for a good history and physical, the proper (not profligate) use of diagnostic and treatment services, proper referral, and proper distinction between when the hospital or home is preferable to the office. In the office, finances should be discussed fully with the patient so that they are completely understood. The rationale behind fewer home calls must be discussed. There must be better communication with the patient about what is happening and why. And there must be less self-consciousness about physician groups. If a group enables a man to practice better medicine (he may feel it does or may not), he should welcome it rather than fight it.

Hospital—The physician must take active part in medical staff organization, even though at first it may seem a waste of his time. He must become more active on committees. He must insist that qualified men not be excluded from the staff for economic reasons. The problem of distribution is caused in part by the difficulty of young specialists getting established. He must promote rather than resist stronger boards of trustees and administrators. Without them, the hospital will drift to the disadvantage of the private practitioner.

Local Medical Society—The local medical society must concern itself with practice outside institutional boundaries at the local level, keeping in mind that a man is licensed to practice medicine and surgery for life even though he may be out of date in two years. Meetings must be held with key groups such as lawyers, executives, labor representatives, and legislators to discuss issues that are concrete with neighbors rather than to discuss abstract problems with unfamiliar persons. Physicians who step out of line financially or otherwise must be dealt with promptly and fairly.

State Medical Society—At this level, practitioners in concert must develop a better integrated philosophy—one that is flexible and realistic. They must sponsor studies to get dependable answers to contentious points about quality and abuse and then support the implementation of appropriate controls. They must develop strong pipelines to the state health department, the welfare department, the insurance commissioner and the legislature among others not for romance purposes entirely, but armed with useful facts, to educate. They must hire competent staff skilled in specific arts such as administration and research. They must concern themselves with placement of physicians.

National Medicine—Physicians at this level must change their image by acting differently in stressful situations. They must curb the tendency to depreciate almost reflexively other points of view. They must sponsor fact finding of a broad scope. They must support centralization (for example, Blue Shield) when it is necessary to meet national markets rather than to express continued concern about local prerogatives. And they must be ready with positive alternatives before the fact of crisis.

Prepayment and Insurance—First and foremost, physicians must practice sound medicine with an eye toward the economic consequences of prescriptions. They must be willing to produce standards and measures for use by prepayment and insurance agencies so that the public can be assured that all is going well. They must remember that prepayment and insurance have a marketing as well as a service side. They must accept that they need men at the helm who can wed sometimes contradictory issues and get things done. Such men should be actively sought and given wide scope of authority and responsibility. A private practioner cannot possibly know all he needs to know about social enterprise. It is all right for him to attempt to reflect common professional sentiments at the policy level, but to impose unrealistic biases not grounded in proper experience is likely to be fatal. The physicians need to develop a point of view toward prepayment versus insurance and then take a stand.

The above are some of many specific points that could be mentioned.

Conclusion

In the future, medical science will continue to grow at a fast rate, making the application of what is known even more complex than it is. Large markets will continue to be influential, as the bellweathers of consumer prejudice; costs will continue to rise, and prepayment and insurance, through extension, will give even greater visibility to the inherent problems of medical care.

If the private practitioner accepts some major changes as an understandable consequence of a maturing economy and learns to employ institutional techniques to influence other changes in the right direction—if the private practitioner is willing to devote time to medical politics or simply become informed, he may arrest the development of private practice at the level of a public utility, i.e., at a fusing of private and public interest. If he does not, given the cost, intrinsic value and political utility of community health, he runs the risk of public ownership through default in the not too distant future.

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Present Status of Anticoagulant Therapy

Anticoagulant therapy has been discussed from the standpoint of the types of drugs available, their modes of action, methods of administration, methods of control, and individual advantages and disadvantages. Reasons have been suggested for existing differences of opinion as to the efficacy and safety of anticoagulant drugs.

In addition, more recently described and less well known effects of the prothrombin-depressant drugs have been discussed. They include: (1) uricosuric action, (2) bronchodilator effect, (3) reduction of plasma TAMe esterase activity, (4) influence on plasma lipoprotein levels, (5) acceleration of plasma lipid metabolism, (6) antagonistic action to increased blood coagulability resulting from lipemia, and (7) reduction in platelet agglutininability.—Abstract of paper presented by John H. Olwin, Presbyterian-St. Luke's Hospital, Chicago, at 1961 Symposium on Blood at Wayne State University.

Narcotics Addiction in Our Community Primarily an Educational Problem

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"For what avail the plough or sail,
Or land or life, if freedom fail?"
EMERSON

OUR MICHIGAN community is truly and abundantly humane. Every one of its citizens naturally wants to live up to the highest level and magnitude of his human being, and needs to find out for himself just how he might achieve this goal. He is frequently aware of the grievous troubles which he has brought upon himself by lack of understanding, and often seeks ways to educate himself so that he may escape the awful consequences of ignorance and disregard. *He may not always realize the fact that there are degrees of knowing anything, and that the true measure of his fully knowing anything is his ability to act upon that knowledge in the most helpful way.*

For nearly all of the health disorders existing in our state, there is already activated citizen devotion towards securing adequate medical care. One most dangerous health deviation, drug addiction, continues to cry out to every kind and thoughtful citizen for his humane interest. That interest will not be withheld, once the citizen recognizes that his beloved homestead does harbor a terrible plague spot.

Next year completes a decade of continuous work of Detroit's Mayor's Committee for the Rehabilitation of Narcotic Addicts. Each member of this committee is thoroughly convinced that an educational campaign is the *specific* measure required in order to enable every citizen to learn for himself the gravity of the poisonous conditions existing in his very own immediate surroundings. Where drug addiction is, there is lack of informed civic spirit, slackening of respect for law, and cancelled enjoyment of peace. The fearful incidence of addiction to drug poisoning in our midst can be reduced only through the *force of education*, which means, through the force of every citizen's educating himself regarding its elimination, or its disastrous effects. This article reports some of my medical experience derived from alerting myself with regard to (1) established facts of existing drug addiction in my own community and (2) discovered facts as to how this disease of the soul, mind and body can be cleared up by reliably *practical* medical treatment.

Drug addiction itself is well defined as an overpowering impulse for intoxication by any drug possessing intoxicating properties; the overpowering influence of the drug succeeding the overpowering impulse for its use. The intoxication may be periodic or chronic. There is a tendency to increase the amount of the drug on account of the user's tendency to develop tolerance for it. The chief characteristic of the addict patient is his compulsion to use medicinal substance, either depressant or excitant, without benefit of medical insight and medical orientation. His satiety from his drug is essential to his going on living. He knows that, without special help, he cannot endure the pain, frustration and longing necessary for his curing himself. Opium and its derivatives such as morphine and heroin or, to a lesser extent, cocaine, produce best examples of extreme narcotization. Other examples of addicting drugs are well known, such as the barbiturates, marihuana, alcohol, paraldehyde, chloral, ether, and chloroform. Alcohol is usually considered separately as constituting the addiction of alcoholism. Love of money is the nature of the ideal that motivates illicit drug traffic of world-wide extent in what is suggestively called "junk." Self-preservation in one form or other is the nature of the ideal that motivates the patient to turn to illicit narcotics. His is what Peyton described as "a solitary shriek, the bubbling cry of some strong swimmer in agony." He may complain of his desperate health status chiefly *by avoiding* physicians except to secure his self-prescribed treatment.

The Author

JOHN M. DORSEY
M.D.



The awareness of the seriousness of drug addiction requires unremitting cultivation. In the opinion of every member of our Mayor's Committee, "the man on the street" has only the most fragmentary and incomplete knowledge of this grievous citizenship problem as it exists in his Detroit community. At the present time, there is an estimated total of 60,000 American drug-addicted persons, of whom about 46,000 have been officially reported. Whittier's spirited words apply again, "slaves—in a land of light and law." It is reliably estimated that there are in the neighborhood of at least 3,000 narcotic addicted fellow citizens of ours living in Detroit. According to the latest statistics compiled by the Federal Bureau of Narcotics, Detroit ranks fourth in the nation in the incidence of addiction.

The "narcotic habit," a highly important disease for every resident of the State of Michigan, particularly of our metropolitan Detroit area, is entirely too broad a subject for me to try to cover, and my physician reader knows that best. On the other hand, it is a community failure of most critical significance for every one of us. It is most disturbing, and we are most disturbed about it. I have elected to review this serious illness only from the standpoint of some of its major aspects, merely noting that its ideal therapy calls for highly trained experts (physicians, nurses, and medical assistants). As many a practicing physician can testify, treatment of his narcotically addicted patient tests all of his medical skill and personal insight. Each of my readers can add further detail through his own medical experiences.

> "Art thou less a slave because thy master loves and caresses thee?"
>
> PASCAL

The kind of individual prone to narcotic dependency is one whose appreciation of his life is not well developed. As a rule, he is discontented with his lot, feels discriminated against, underprivileged, and above all, *not loved and unable to love*. He lacks a sense of his own self-importance as an individual and tends to feel that the dignity of his individuality has been disregarded. He is lacking in self-reliance and inclined to seek someone else or something else to trust. His self-disesteem may show itself either in feelings of unhappiness and associated self-accusatory ideas of unworthiness, or in the ideas and feelings that his fellow men are not important, are not proper objects of esteem. By taking a drug, he succeeds both in feeling like a "somebody," and in withdrawing his interests from his uncaring fellow man. He enjoys toxic "equalizing" sensations which function as an artificial release from inferiority feelings and as a substitute for his natural self-respect.

The unscientific designation, "drug addict," includes persons of very different levels of mental development and, hence, of differing capacities for self-help. However, either through foreshortened mental development, or through regression from a more advanced to a more primitive kind of life orientation—or through both, a neglected drug-addicted person tends to feature certain conspicuous character traits. His extreme impulsive urgency to gratify his need for immediate freedom from mental tension is ostensibly his chief distinction.*

Basically, he seeks freedom from his feelings of unhappiness. His intoxication does not make him violent —quite the contrary. He is inclined to be passive. As one dependent patient volunteered, "The only time I would run, would be from the police or towards my drug." Another destitute patient confided, "My drug is like a baby's food formula. I am just like a baby. As soon as I get it, all I want to do is lie asleep in my crib. Without it, I have a powerless hopeless kind of life and feel that there is nothing I can do with my unhappiness." Unless he is able to secure adequate therapy, he may go on to increasing dependence upon his medication. His self-administered "dope" feeds his master passion, and, as Pope pictured it, "Like Aaron's serpent, swallows all the rest." The more drug he takes, the greater tolerance he develops, so that it requires increasing amounts of a drug to produce anything like the same artificially produced sensations of self-worth. Nevertheless, his drug continues to be his unenlightened first-aid, without which he could not care to go on living. *It is nothing less than a life-and-death struggle in which he finds himself.* Having himself told that he ought not be the way he is, is likely to be the extent of help he derives from his uninformed neighbor who cannot understand his extremity. My fellow man who helps himself with narcotics is saying, "Anyone extremely ill as I am needs, above all, to be able to live himself as cared for, as a worthy human being."

On the other hand, as he attempts to withdraw from his drug taking, he suffers unspeakable anguish. He undergoes exorbitant demands for money to meet his extortionate drug costs. His longing for his intoxica-

*In technical terms, he cannot renounce his archaic oral longing: his deep primitive desire for satiety, his passive narcissistic aim to be "taken care of." His genital organization undergoes undifferentiation and his drug becomes his all consuming love object. He maintains interest in his deliverer, the drug procurer. His preferred "touch with reality" is hypodermic.

tion, and his pain and terror without it, are so urgent that he cannot afford to be too particular about the way in which he secures this money. Thus, various kinds of private hell, even to the extent of destruction of human life, may become a part of his existence during such struggles.†

Evidence does not indicate that a narcotic addicted patient suffers irreversible mental deterioration. If he is able to recover his freedom from dependency upon the drug, and in turn from dependency upon his physician, he acquires the mental strength derivable from his successfully struggling through these difficulties, by suffering rendered sager, self-reliant, self-insightful. "Once an addict, always an addict" is no medical diagnosis. It is an understandable condemnation by one who has not yet been able to come to grips with, and renounce, his own defeatest *habit* of mind.

It is a well-established medical finding that the addicted person responds to proper treatment under confinement and will remain permanently cured when his drug using stops, and he is otherwise enabled to restore his health and strengthen his will power. Every instance of drug addiction is a unique one requiring *individual* study and treatment by a medical expert who has specialized in this particular field of drug addiction. Abstinence and the development of self-reliance based upon recognized self-knowledge, are the necessary steps back to healthy living.

"Narcotics Anonymous" is the name used by addiction suffering persons grouped courageously to combine their forces of resistance to addiction and of respect for the dignity of human individuality.

A Detroit citizen suffering from his ruthless and desperate addiction to drugs right now does not have the full opportunity he needs for recovering his health. He fears that he must live until he dies paying with his soul for his body's desire. Indeed he is skeptical as to whether there is any possible chance anyhow for him to restore himself, apart from his getting humane chemical detoxification to reduce the cost of his "habit." *He needs to be rescued.* It is the right and responsibility for each member of his family, neighborhood, and greater metropolitan community, to provide this hygienic rescue. It is peculiarly contra-indicated for an American citizen to be exploited by any form of forced servitude, and slavery to the "illicit drug traffic" is most offensive of all of life's circumstances.

†Only my seeing my personal identity in my "narcotic addict" can suffice to keep me working in this most difficult field, so easy is it for me to hate what I fear. However, it has been precisely through this kind of work that I have been able to develop a most cherished degree of medical hardihood.

"How happy is he born and taught that serveth not another's will"

WATTON

Man's effort to try to help himself get through his painful ordeals by using drugs occurred in his primitive ancestors, so that its beginning is lost in antiquity. It is only good sense to assume that his discovery of drugs for escaping pain and catching pleasure was one of his earliest findings. The first use of narcotics reported is that of people in what is now Iraq, 5000 B.C. The great Greek physician, Hippocrates, in the fourth century, B.C., recommended white poppy juices for a variety of illnesses. Early Egyptians knew of the important medical value of narcotics. The Spaniards while conquering and exploring Latin America found the natives were stimulating themselves by chewing the coca leaf, from which cocaine derived its name later.

Since the seventh century A.D., opium traffic has been known, and was begun by the Chinese. Paracelsus (1490-1540) eulogized it as "The Stone of Immortality." The Portugese and Dutch carried it on in the East before English merchants of Calcutta started it, when its control passed to the East India Company about 1781. Throughout the 19th century in Europe and in America, opium was used by the medical profession for almost every malady.** In 1803, Derasne separated the alkaloid base from opium and named it "Morphine." In 1845, a hypodermic syringe was invented by Rynd of Dublin, his hope being that injections would reduce the force characteristic of oral habituation. In 1898, Dresser, a German, discovered the opium derivative heroin, hopefully claiming it was not habit-forming and would cure opium addiction. Analogous discoveries and claims of "curative" drugs continue in our time.

Narcotics started deadening us Americans even before our Declaration of Independence. Successful rebellion against the tyranny of intoxication is not yet accomplished. Before the Civil War, the hypodermic needle was introduced here. In the latter half of the 19th century, drug addiction increased. "Panacea" medicines containing narcotics began to spread. At the end of the Civil War, estimated thousands of soldiers who had received numerous injections to relieve their sufferings from wounds and sicknesses, began to rely more and more heavily on this form of immediate and unfailing escape, as if satellites to a syringe. With the growth of advertising of patent

**See Dr. C. E. Terry's account, Encyclopedia of the Social Sciences, Vol. 5, page 243.

"remedies" containing narcotics, many other newly emancipated citizens became dependent upon the misusage of such medicines.

After World War II, heroin smuggling and peddling increased, and more teen-agers became problems of addiction. Commissioner of the U. S. Treasury Narcotics Bureau Anslinger, estimates 12 per cent (5,000 or 6,000) of addicted individuals are under age twenty-one. I am pleased to report that, in Detroit, this percentage is very much lower, and that for years now no cases of addiction have been found in our schools (thus far). However, it must be acknowledged, indescribably distressing as it is to do so, that every infant and child associated with an addicted person is a casualty of this dread disease.

Heroin has no official medical use in the United States, and is entirely a contraband chemical. Nevertheless, at the present time it, along with other illicitly sold drugs, provides outlaw trade in human character, including huge criminal financial profits. An addicted person may spend $5 or $10 to $100 or more a day to gratify his craving. It is estimated that an extremely high percentage of addicts (90 per cent) are involved in crime in order to be able to support their habit. This kind of spending, wild as it is, is not to be compared with the addicted person's extreme investment of his morality, of his ideals, in his soul-consuming illegal and non-medical use of drugs.

"Oh! let me live my own, and die so too!"
POPE

It appears that the first alarm about the dangers of narcotic habituation sounded in the 18th century when the Chinese emperor Yung Chen prohibited the smoking of opium. Reportedly, Chinese habitues paid little or no attention to their emperor's command. First international conference to control the narcotics traffic was held in Shanghai in 1909. Other meetings have been held at The Hague in 1912, 1913 and 1914 and at Genoa in 1920, 1924, 1925 and 1931. The chief problem in these conferences seemed to be how to limit narcotic production without restricting the revenue derived from it.

For well over a hundred years, the United States has had legislation attempting to restrict opium imports. In 1906, passage and enforcement of the Federal Pure Food and Drugs Act proved to be a very helpful measure. Meanwhile, members of the medical profession were becoming increasingly apprehensive of the employment of narcotic drugs. In the early 1900's, there was an increase of teen-age heroin addiction. During World War I, it was estimated that there was at least a total of 200,000 Americans addicted. The passing and enforcing of the Harrison Act of 1914 was another tremendous help. The purpose of this Act is to police the production and sale of narcotics, to make sure that drugs go through professional channels and are used only for medical and scientific purposes.

In 1930, the Federal Bureau of Narcotics was created in the United States Treasury Department at Washington. Additional national efforts to control narcotic usage have been: the Marihuana Tax Act, the Narcotic Drugs Import and Export Act, Controls of Synthetic Narcotics, and the Narcotic Control Act of 1956.

In 1935, the first federal hospital for the treatment of narcotic addicts was opened in Lexington, Kentucky. Now the Lexington and Fort Worth federal treatment facilities together have 2,200 beds. Federal hospital treatment was a most commendable development. It led ultimately to the full realization, now shared by all of its workers, that *local*, and not far-removed, hospitalization is the treatment requirement which must be heeded.*

The United States, along with more than eighty other nations, is working hard upon the control of narcotics both with respect to smuggling and transportation within our borders. Also federal and local narcotics bureau officers vigorously try to reduce theft of narcotics, forged prescriptions, and other sources of supply.

In this country, the effort to operate government-sponsored clinics to distribute narcotics to addicts appeared to make the whole situation worse. In 1924, a special committee report of physicians of the American Medical Association urged federal, state and local governments to exert full powers and authority to put an end to all manner of ambulatory methods of treatment of narcotic drug addiction whether practiced by a private physician or by the narcotic clinic dispensary. The report added that the only proper and scientific method of treating narcotic drug addiction is under complete control of both the addict and the drug by the physician directly responsible for the medical conduct of the addicted person's treatment. By the middle nineteen-twenties, all the clinics were discontinued. Condoning "free drug areas" instead of striving for "drug free areas" violated the spirit and purpose of international agreements and also demon-

*Dr. Murray A. Diamond, Medical Director, United States Public Health Service Hospital, Lexington, Kentucky—personal communication.

strated that drug addiction is a kind of health deviation which requires *compulsory* hospitalization. There is no such management as a "maintenance dosage," only increasing tolerance which means increasing appetite for greater amounts of the drug to produce the same amount of satisfaction.

In our metropolitan Detroit area as well as in the state and in the nation at large, every physician has been serving the cause of preventing and curing the mental and physical wretchedness known as "narcotics addiction." Our MSMS Mental Health Committee has been studying this problem for years, and many a helpful development is traceable to its efforts. Particularly, its members see the need for upholding the importance of making it an educational issue and for keeping it as a continuing study project. Not only in medical education but also in general education, efforts have been steadily exerted to clear up this critical public health ordeal.

The earliest recorded survey of narcotism in Michigan, of which I have knowledge, is that of O. Marshall in 1877: *The Opium Habit in Michigan*, Annual Report, Michigan State Board of Health, 1878.† Marshall's report was an incomplete one. In the first place, he had no data from the larger cities. Secondly, as he acknowledged, the information which he secured from physicians was less complete than would have been that secured from druggists. Thirdly, he used state population figures for 1874 instead of 1877. He calculated about 2,250 Michigan users. Marshall stated:

"At a meeting of the State Board of Health in January, 1877, by a written communication, I called its attention to the large number of opium-eaters in the vicinity of North Lansing, giving many particulars relating to the opium habit as it exists here. In complying with the request of the Board to prepare an article for publication, I have extended the investigation to other parts of the State, the result of which investigation is here given.

"Those best acquainted with its extent are the physician and druggist. As a rule, the physician, although originally responsible for many of the cases in his vicinity, is only aware of them through his business relation with the druggist. The latter, from whom the drug is obtained, from the fear of loss of trade, or, as some of them term it, a violation of confidential business, are often unwilling to furnish any information with regard to it.

"From the supposed impossibility of getting reliable information of the numbers in the larger cities, no circulars were sent to Detroit, Grand Rapids or East Saginaw; and probably from this cause no answers were received from many of the larger cities of the State where circulars were sent.

"The total number of opium eaters reported in the places given is 1,313; of these 803 are females and 510 are males.... The population of the cities and villages including the townships in which they are situated, according to the State census of 1874, was 225,633. The population of the whole State at the same time was 1,334,031. If the number of opium eaters, including morphine eaters, in proportion to the population in the places given holds good for the entire State, the total number of opium eaters, all classes, in the State would be 7,763. Taking every degree of the habit into consideration, this estimate of the number is probably not too large.

"The opium-habit in this country seems to arise from many different causes, prominent among which is the indiscriminate use of medicines without intelligent medical advice. Few families are to be found who are without their stock of remedies. Common among these are opium, morphine, Dover's powder, laudanum, and paregoric, besides the domestic prescriptions containing opium. For the nursery, in addition to the common opiate preparations, are the patent soothing-syrups, cordials and anodynes, nearly all containing opium.

"To show to what an extent the dosing of infants with opiates is carried, it is claimed that over three-quarters of a million of bottles of Mrs. Winslow's soothing-syrup are sold annually in the United States. According to an analysis made and reported in the *California Medical Gazette*, each bottle of this syrup contains from one-half a grain to one grain of morphine. Placing the average at three-quarters of a grain to each bottle, the amount of morphine used in this manner would be 562,500 grains, or about 1,171 Troy ounces —enough to kill a half million of infants not accustomed to its use.

"From the predisposition to nervous and neuralgic affections produced by it, probably many cases of opium-habit in the adult have their first cause in the use of opiates in infancy and childhood. A want is created in the child which is satisfied in the adult when opium is taken, tolerance being already established.

"The most frequent cause of the opium-habit in females is the taking of opiates to relieve painful menstruation and diseases of the female organs of generation. The frequency of these diseases in part accounts for the excess of female opium-eaters over males.

"Undoubtedly, in many instances, physicians are directly responsible for the habit, in continuing the medicine too long, or too frequently resorting to it; but more often the opiate is prescribed and afterward indefinitely continued without the physician's knowledge or consent. The prescription intended for a day is repeated by the druggist many times, and its use is continued until the habit is formed. I believe there is no effectual law to reach these cases or prevent the sale of opium in any quantity. At present, it would not be difficult for a lunatic or a child to obtain at the drug stores all the opium he called for, provided he told a plausible story and had the money to pay for it."

For the period of July 1, 1925 to June 30, 1926, a study was made and its results published: *Report on The Legal Use of Narcotics in Detroit, Michigan and Environs*, New York, 1931. The report was ad-

†*The Opium Problem*, by Charles E. Terry, M.D., and Mildred Pellens, Haddon Craftsmen, New York, 1928. It is noteworthy here, also, that to Michigan goes credit for the earliest survey made in the United States.

dressed to the Bureau of Social Hygiene, 61 Broadway, New York, N. Y. It was part of an effort to decide, through sampling the opium needs of certain areas, the actual amounts for medical and scientific purposes required under all conditions for the continental United States.

The research was conducted by C. E. Terry, M.D., Executive, Mildred Pellens, M.D., Associate Executive, and J. W. Cox, M.D., Field Worker. The records reviewed in Detroit elicited the existence of 511 legally supplied addicts to opium and its derivatives. This was a minimal figure, as some patients received their medicine directly from their attending physicians. Of the latter, no information was attained. In addition, 734 illegally supplied addict patients passed through the Detroit police headquarters during the year. Police estimates of illegally supplied addicted citizens were from 10,000 to 12,000. The Summary recommended that the medical profession take "especial care to meet this situation," adding, "greater emphasis should be placed in medical schools on the dangers of addiction formation." The study indicated the desirability of continuing inquiries relating to the therapeutic use of drugs as a part of a program for preventing and controlling addiction.

In the early nineteen-thirties, under the supervision of the Narcotic Educational Association of Michigan, Inc., a farm for local treatment of the narcotic addicted person was maintained at Capac, Michigan. Reverend E. J. Rollings, member of our Mayor's Committee and Dr. Thomas J. Heldt, esteemed Detroit psychiatrist, participated in this movement. Their experience demonstrated that the operation of an institution for the treatment of the narcotic addicted citizen requires special skills, steadfast devotion, constant application, and closely supervised organization. The Capac farm was a noble experiment. It continued for a period of three or four years and was definitely of acknowledged helpfulness. "God helps them who help themselves" is a proverb in all languages. Aeschylus said it, "God loves to help him who strives to help himself." Self-help was a powerful principle of this project. What each Capac patient lacked most, but also needed most, to help himself was his enforced abstinence from intoxication.

Twenty-three years ago, a Survey Committee studied narcotic addiction in Detroit, particularly from the standpoint of its contributing to petty larceny.** The Foreword by Lent D. Upson, stated:

"The merchants of Detroit, like the merchants of most large American cities, suffer large annual losses as a consequence of the activities of kleptomaniacs, of petty larcenists who steal goods for personal use, and particularly of drug addicts who steal articles for resale in order to purchase the means of satisfying their addiction. This last group, known to the police as 'hop heads,' 'dopes,' or 'junkers,' is believed to account for the largest losses—due to continuous activities, the resale of stolen property to 'fences' at a fraction of its value, and to the consummate skill with which the thievery is carried out.

"This study of narcotic addiction as a factor in predatory crime, particularly petty larceny, was undertaken at the instance of the Retail Merchants Association of the Detroit Board of Commerce and a Joint Narcotic Committee appointed by the Wayne County Medical Society, to learn, if possible, something further concerning the number of addicts, the character, extent and cost of their drug consumption, the nature and amounts of their thieving, to which might be appended recommendations for curtailing the resulting loss to Detroit merchants and others.

"The Survey Committee consisted of:

Clarence H. Eisman, M.D., Wayne County Medical Society, Chairman of the Committee.
Charles E. Boyd, Retail Merchants Association, Secretary of Committee.
Ray S. Dixon, formerly Social Hygiene Director, Department of Health.
Percival Dodge, Secretary, Detroit Community Fund.
Don W. Gudakunst, M.D., Deputy Commissioner, Department of Public Health.
Ora Montgomery, formerly Secretary, Detroit Association of Credit Men.
John P. O'Hara, President, Board of Commissioners, Detroit House of Correction.
Lent D. Upson, Director, Detroit Bureau of Governmental Research and the School of Public Affairs and Social Work of Wayne University.

"To finance this experimental study in an area exceedingly difficult of exploration and in which little or nothing is known, an initial grant of $500 was made by the Detroit Community Fund to the Detroit Bureau of Governmental Research, which fund was supplemented from the Bureau budget, and under whose auspices and general direction the survey was made."

This report indicated the great difficulties in estimating the number of addicts illegally supplied with drugs in Detroit. Estimates ranged from 1,000 to 12,000, "with the top figure probably a casual exaggeration." Report No. 9 used the figure of 500 as the basis of its calculations. It concluded that the

**Report No. 9 of The School of Public Affairs and Social Work of Wayne University, entitled, "Narcotic Addiction as a Factor in Petty Larceny in Detroit," by Edward C. Jandy, Assistant Professor of Sociology, Wayne University, and Maurice Floch, Psychologist, Detroit House of Correction, November, 1937.

narcotic addict's "depredations upon community merchants result in large annual losses to them; his larcenies provide extra strain on law enforcement agencies, courts and penal institutions."

Of Report No. 9, the Narcotic Committee of the Wayne County Medical Society, June 8, 1938, reported, "It is an excellently done, thorough piece of research of its kind and conveys a good deal of information to the medical profession and to those who are interested in this problem and . . . it shows many signs of careful, painstaking work on the part of its two authors."

After further comment, including mention of certain necessary shortcomings in such a limited study, the Committee report added, "It is true that some provision should be made by which an offender who is addicted to the use of habit forming drugs could be hospitalized." It summarized, and please note that this summary has its value for today's needs, too:

"Your committee recommends that a hospital be set up that can take care of some one hundred to two hundred drug addicts and perhaps an equal number of alcoholics each year. They must be committed and not accepted as voluntary patients and your Committee would further recommend that some sort of a clinic be provided not particularly for drug addicts but where drug addicts would go among other mental patients for advice and help and, if need be, to pave the way for commitment for actual psychotherapeutic treatment and cure. Your committee would emphasize the need of social service treatment, adjustment occupationally and economically, and also some supervision after release inasmuch as a cure is not accomplished by mere hospitalization."

All help is self-help, but a narcotic addict patient specifically needs to help himself by having himself restrained. After he has detoxified himself, there is a clear possibility that, with sufficient community understanding and practicality, he can continue to help himself outside of a hospital. The duration of his hospitalization, of the kind I shall describe, is an individual problem varying from two or three to six or eight weeks.† The duration of his out-patient treatment is also an individual matter, but would seldom, if ever, be less than one year.

On March 12, 1951, Mayor Albert E. Cobo saw fit to establish the Mayor's Committee for the Rehabilitation of Narcotic Addicts. Every member has taken satisfaction in seeing to it that his is a hard-working committee. Although this committee has made great progress, from time to time one of its members understandably becomes dissatisfied with its rate of progress and, instead of using that dissatisfaction as a motivation for greater effort, is strongly tempted to discontinue his committee effort entirely. The committee member's civic spirit and high-minded morale are outstanding and consistently win out. From the start, the whole committee has operated with three sub-committees: legislation and law enforcement, diagnosis and therapy, and education and research.‡

Mayor Louis C. Miriani, thoroughly familiar with the intent and work of this committee, from its beginning, has seen to its uninterrupted continuation, and has made every effort to advance its cause of educationally furthering prevention and treatment. Mayor Miriani's finely conceived and practically administered Austerity Program allows for his high-minded recognition of his fellow citizen whose soul cries out to be rescued from the snares of self-imposed intoxication.

On January 30, 1953, the whole committee submitted a carefully and caringly prepared report of 172 pages. This publication included twenty-four specific recommendations. Compiled and written up by the committee's executive secretary, Mr. Donald M. D. Thurber, this publication proved helpful nationally and internationally. Unfortunately, the edition consisted of only 1,000 copies which soon ran out. This statement occurred in it:

"The symptoms of disease have profound health significance for the specialist who has grown to see them even as cheering signs showing the way into, and therefore out of, human trouble. Our unprepared fellow man, however, cannot see these abnormalities with the healthy encouragement and hopefulness inherent in the doctor-patient attitude, so that his morale is not strengthened by accounts of painful living. Indiscriminate publicizing of human suffering, although intended to alleviate it, may add to the sum of human misery. The few detailed descriptions of illness in this report have been included by majority rule of our Committee. May any appearance of fault-finding in the report be relieved by the health-affirming insight of deepest appreciation for the indispensable directions to human welfare provided by the signs and symptoms of disease."

Through the work of the Committee, it was possible to establish an out-patient narcotics clinic in the Detroit Department of Health.* Other accomplished objectives it helped to secure were expansion of our Detroit Police Department Narcotics Bureau, legislative changes facilitating compulsory hospitalization of the narcotic addicted person, and augmented educational programs in schools, churches, and other community agencies. It has steadfastly urged the establishment of a *local* in-patient compulsory treat-

†Chronic severe illnesses require much longer in-patient treatment.

‡Respective sub-committee chairmen are Rev. E. J. Rollings, Dr. Thomas A. Petty, and Mrs. William G. Koerber.

*Director, Dr. William J. Wertz.

ment center combined with *local* follow-up out-patient compulsory care. These two projects, the details of which were arranged by committee member, Dr. Herbert A. Raskin, have been found useful not only for national, but also for international, planning purposes. Every member of the committee has felt the need for the continuation of its work in vigilant research and persevering education.

Our Mayor's Committee has received the finest kind of cooperation from every city department and particularly from those with whom it has had to do the most study: members of the Board of Education, the Public Health Department, and the Police Department.** A similar kind of fine cooperation has been forthcoming from our legislators and from our court judges.

> "Separatism . . . is the abstraction of a negation, the shadow of a shadow."
>
> AMIEL

Although narcotism is strictly a disorder of health, as a rule, it does also involve illegal usage. Hence, it is *essential* that physician, judge, attorney, legislator, and police officer undergo the study and research necessary to make sure that the proper focus upon the narcotist is that of *a patient suffering from a serious illness*. With this orientation, everyone is in the best position to be helpful.

Experiences in our Detroit Narcotics Out-Patient Clinic bear out the findings of all physicians that it is necessary for *every* citizen to avoid non-medical narcotization. No one is regarded as sickness proof. Proper health precautions require that every patient have his physician prescribe any and every kind of drug of intoxicating properties. Both the chemical structure of the medicine and the psychological structure of the patient contribute to this addictedness. Morphinism, opiumism, and every other kind of narcotism, refer to a person suffering disordered health. Said Thomas Jefferson, "The God who gave us life gave us liberty at the same time." Liberty and addiction are incompatible.

Sometimes the declaration is made thus, "Physicians have been known to continue successful practices while actively addicted." Such assertions may be most misleading. Everyone, physician or patient, is undergoing a serious health struggle involving the very essence of his appreciation of life itself, as long as he is dependent upon narcotization for the conduct of his life. Healthful self-esteem and dependency upon a drug for making life seem livable, are not the same formula for successful living.§

At the present time, our Mayor's Committee, to the member, has reached the following realization. For the adequate treatment of the Detroit citizen who is suffering from narcotic addiction, there is needed a local in-patient highly specialized kind of compulsory treatment combining psychiatric with general therapy. In addition to this strictly local in-patient care, there is needed a very active follow-up local out-patient type of compulsory treatment.

It is important to note right here that "compulsory treatment" is no exception to the truth that all help is self-help. A person who consciously persists in refusing to treat himself, is unconsciously requiring that he have himself rescued from this suicidal attitude. A sick person of this degree of self-disesteem must be cared for as if he were only a baby. One does not demand that a baby be able to declare his intention to take proper care of himself. The addicted individual, like the lost sheep, needs to be sought for and needs to live passively his returning himself to the fold. These are legitimate medical needs. He is already suffering hurt feelings of segregation and needs convincing experiences that his family and community really belong to him. It is most essential that every patient be able to force upon himself the opportunity of medical supervision by his personal physician, not only during his hospital stay but also throughout the time of his effort at adjusting himself for the living of his community and for the resumption of his occupation. In addition, members of his family, as well as certain members of his greater community, need definitely and critically to have opportunity for developing the kind of understanding which will make it possible for each of these individuals to behave usefully, instead of harmfully, while the patient is attempting his rehabilitation. Over the years, experience has indicated beyond any doubt that an addict patient, in every instance, is an emergency case deserving medical treatment not only *when he needs it*, but also *where he needs it*.

The United States Public Health Service, through its National Institute of Mental Health, has expressed a willingness to subsidize, for the most part, the establishment of the kind of in-patient and out-patient treatment unit described, *provided that local funds also contribute to the project*. The federal subsidy would

**Special mention is due Inspector Russell J. McCarty in charge of Detroit's Police Department Narcotic Bureau, Mr. Ross Ellis of the Federal Narcotics Bureau, and Mr. Ernest F. Rossi (now deceased), each of whom has devoted himself without stint to furthering the Committee's effectiveness.

§Professor Walter H. Seegers, Chairman of the Department of Physiology and Pharmacology, Wayne State University College of Medicine—personal communication.

amount to approximately $200,000 a year; the local investment in community health would approximate $60,000 a year. This facility would treat 200 addicted citizens a year. Sufficient space for this clinic has been made available by the Detroit Department of Health. Federal Commissioner of Narcotics H. J. Anslinger regards this solution as being an extremely worthy project which has his unqualified approval and support. He realizes keenly that without provisions for local treatment of Detroit's addicted citizens, the problem of enforcing the narcotic laws here must continue to be a tremendous one. In his view there should be established in Detroit, as soon as possible, this adequate treatment center providing facilities for physical withdrawal, intensive psychiatric treatment, a follow-up program for at least two years, and continuing health education aimed specifically at drug addiction prevention.

Every member of our Mayor's Committee is now interested in mobilizing Detroit's civic spirit to deal realistically with our critical public health problem of drug addiction. Health-conscious men and women workers of every kind, including doctors, lawyers, educators, ministers, editors, lecturers, and particularly every elected and appointed public servant, each one needs to educate himself about his Detroit drug addiction seriousness and its implications for every possible part of community living.

The development of the *practical* kind of required local in-patient and out-patient general and psychiatric treatment just described, brings *medical realism* into the picture of narcotics addiction. A narcotic addicted citizen would rather not consider himself as ill, particularly as mentally ill, which he certainly is. Similarly, the "drug peddler" would not like to consider himself as the madman, which he grievously is. As long as this *medical realism* herein described is not applied to the treatment of the condition, it will be possible for the organized "dope peddler" to go on regarding Detroit as a likely target for his aim. On the other hand, if the so-called "pusher" requires himself to face the *medical reality* of having himself diagnosed a psychiatric patient requiring psychiatric treatment over an indefinite period of time, this kind of reality orientation would be his chief deterrent, the one deterrent which is now sadly lacking in force.

James Clayton presents convincing statistics* to show the immense advantage of psychiatric hospital treatment over incarceration for the "criminal's" enlightened care. As an offering to any critic who regards Judge David L. Bazelon's renowned Durham case rule ("acquittal by reason of insanity must result if the crime was a product of mental disease or defect") as being "an easy way out" of responsibility, author Clayton concludes, not without humor, "Almost anyone in his right mind would prefer a term in prison to a term in a mental hospital."

"Thank God for the iron in the blood of our fathers."
THEODORE ROOSEVELT

In conclusion, what is direfully needed is a realistic appraisal of the awful health disorder known as "drug addiction," so that medical responsibility and authority can apply itself freely. The illness is of disaster proportions right here in Detroit, and it is the proper concern of every public-spirited person. Education upon the topic, Detroit's Drug Addiction Endemic, is a needed sign of the aroused spirit of Detroit, ever-ready to build itself out of its ashes. First things first, the rescue of our despairing fellow citizen from his slavery to his habit is a Detroit First. Effective education of the individual citizen, by himself, is a necessary initial step. He must first see clearly that he goes to bed with this horrible treason at night and gets up with it in the morning; then, outraged, he will begin to demand in the name of his vitalized patriotism that realistic measures be found and instituted to deliver him from this evil. First of all then education, and continuing education. Said Socrates, "One only evil, namely, ignorance."

Lastly, every instance of drug addiction involves a unique individual whose prognosis for curing himself, in my opinion, is 100 per cent favorable, provided that his treatment is sufficiently realistic. The necessary prolonged duration of the treatment; the necessary relapses which are par for the course of that treatment; the necessary irregularly recurring discouragement, hopelessness and inability to cooperate on the patient's part; the necessary impatience and refusal of the patient's relatives to put up any longer with his "back-sliding"; the necessary frustration of the physician's own therapeutic pride and ambition; the necessary dissatisfactions and resentments of the medical doctor's colleagues who are less experienced for understanding this difficult professional study and practice; and, perhaps, above all, the necessary mental preoccupation of each patient with "externals," with his materialistic ideas of helpfulness to the corresponding exclusion of his self-insight; each of these, as well as other medical necessities, is considered part of the day's work by the physician adequately prepared to diagnose and treat addiction disease.

*"Six Years After Durham," *Journal of the American Judicature Society*, June, 1960.

The Surgery of Deafness

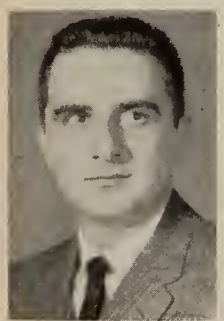
I. Myringoplasty by Bi-Pedicle Flap Vein Graft Technique

Brian F. McCabe, M.D.
Ann Arbor, Michigan

IN RECENT YEARS there has occurred a resurgence of interest in the rehabilitation of the patient afflicted by a conductive deafness, the result of active or inactive suppurative disease. This re-interest has brought about a renaissance in otologic surgery, occasioned at least in part by advances in knowledge of acoustic physiology and its dissemination to otologic surgeons, by the availability of better light, better visualization and better training, and by the painstaking development of new surgical techniques based upon sound physiologic and surgical principles.

A common ear disorder resulting in the restriction of the patient from some sports and also his exclusion from certain occupations is the perforated tympanic membrane. The type of perforation amenable to closure by simple techniques is the central perforation with an undiseased middle ear. If active chronic suppuration is present, simple closure will fail and must be accompanied or preceded by mastoidectomy to eliminate osteitic bone and cholesteatoma when this is the source of the suppuration.

The symptoms of an uncomplicated tympanic perforation are usually only that of a mild deafness and its sequela, tinnitus. The deafness is conductive in nature, with prolonged bone conduction (plus-minus to negative Rinne), and lateralization of tuning forks to that side. When the deafness is greater than 30 decibels (a medium whispered voice at the ear) it is not due solely to the tympanic perforation, and attention must be directed to the entire aural mechanism to determine the cause. The tinnitus is mild and usually of the rushing wind or waterfall variety although frequently none is present. Often there is a history of brief mucoid otorrhea with upper respiratory infections.



The Author

BRIAN F. McCABE

M.D.

Physicians have attempted the closure of perforations for at least a hundred years.[1] Initial attempts involved the employment of animal membranes such as goat conjunctiva and pig bladder; later innovators advocated prepared tissues such as dried amnion, and prosthetic devices including cigarette paper, Koroseal, Korogel, polyethylene, cotton, silastic, and siliconized paper. The disadvantages of prostheses center around their temporal nature. As early as 1876, cautery of the perforation margin was found to promote proliferation until the margins of the perforation met.[2] Silver nitrate was the first agent used for this purpose; now, trichloracetic acid is used almost exclusively.[3] When this method yields success, it is superior to any other method because the gap is then bridged with tissue appropriate to that area, tympanic membrane, which is morphologically unlike any other organ in the body in its thinness, toughness, and acoustic properties. The difficulties here are several, chief among them that not all perforations can be closed by cautery.[4] Weekly cauteries are necessary, requiring in our experience from four to sixty-two visits, with an average of twenty. For the patient to maintain a schedule of weekly visits for longer than four or five months requires more than an ordinary amount of determination. If the patient comes from some distance, as is often the case in my office, this is not a very practical method. A modification of it is used, however, with 95 per cent success, requiring only one treatment. The perforation rim is cauterized in the usual manner and covered with a dried sterile amnion patch, moistened with neomycin solution just before

EDITOR'S NOTE: This is the first of a series of four articles on The Surgery of Deafness. The other articles will appear in future issues of THE JOURNAL.

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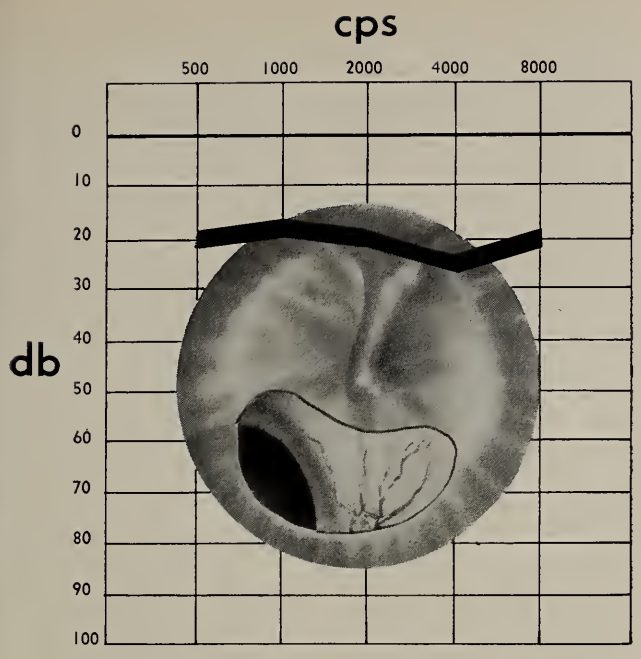


Fig. 1A.

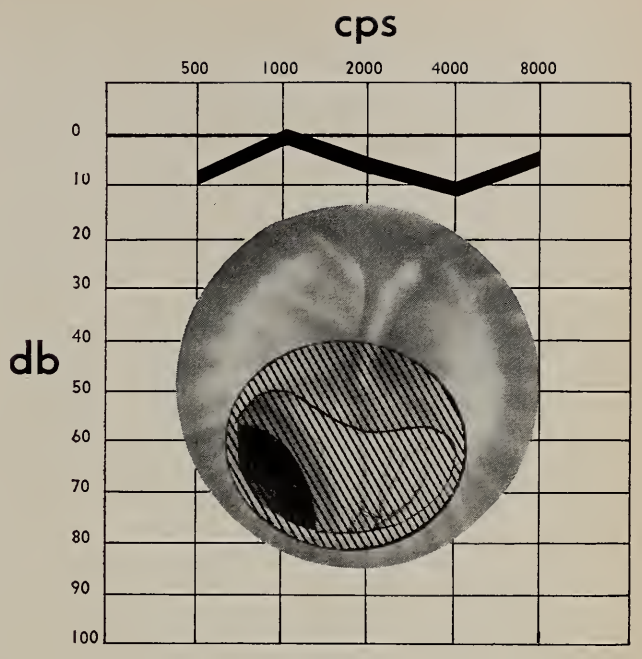


Fig. 1B.

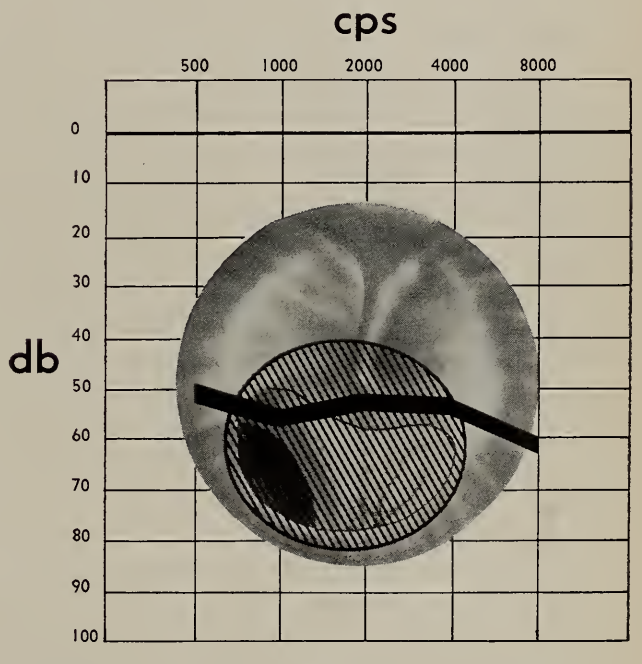


Fig. 1C.

Fig. 1. Patch testing of the middle ear is a simple and effective method of determining the continuity of the ossicular chain. An audiogram is obtained prior to patch testing. In the following case (A), the hearing level is 20 decibels decreased. A tissue paper or plastic film patch is then applied to the tympanic membrane (B). If the hearing level then rises, the ossicular chain may be assumed to be intact. If, however, the hearing level is thereby dropped below its original level, the ossicular chain is disrupted: (C). In this event, ossicular chain continuity must be restored prior to myringoplasty.

application. This has been described by Schrimpf.[8] Patients must be selected carefully, having an entirely central perforation not over 2 mm. in diameter.

The first surgical closure of a tympanic perforation was performed probably by Berthold in 1878, who coined the term "myringoplasty." He was the first to utilize a full-thickness, free skin graft with success, but the method fell into disuse until revived recently by Wullstein[6] and also by Zollner. The outer surface of the tympanic membrane is de-epithelialized and a tailored full-thickness skin graft placed which depends for survival upon an intracapillary circulation. This technique attains a significantly high success rate but it, too, is attended by disadvantages. First, the graft never quite attains the thinness of the natural tympanic membrane. Second, it may not be suitable for extremely wide perforations because the wider the perforation the higher is the rate of graft perforation.[7] Third, graft and canal cholesteatomas can occur years later when the patient may be lost to follow-up.[5] Fourth, for some inexplicable reason, many full-thickness grafts in the ear continue to desquamate heavy layers of moist keratin for months or years.

A method of closure satisfactory for very wide perforations has been evolved which combines several proven techniques. This method employs a viable bi-pedicle full-thickness skin flap from the canal wall and a free vein graft to bridge the remaining gap. Sooy described a somewhat similar technique suitable for smaller perforations utilizing a uni-pedicle flap.[9]

The use of vein as a graft material has been described by Shea and by Tabb.[10] A bi-pedicle flap has the obvious advantage of better blood supply to the advanced tissue. Vein, in the closure of perforations, probably acts as a scaffolding in a manner similar to cigarette paper or amnion, but would appear to be a superior material in that it obtains a blood supply and becomes a living scaffold until its job is done, and then is largely resorbed, leaving regenerated tympanic membrane in its place. Further, it is likely that at least the intimal and subintimal layers of vein wall are accustomed to a low oxygen tension and may tend to survive longer than dermis in the event a prompt intracapillary circulation is not set up.

Requirements for Bi-pedicle Flap Vein Graft Myringoplasty

1. The middle ear must have been absolutely dry to the surgeon's inspection for at least three months. Merely the absence of subjective discharge from the ear is inadequate investigation.

2. Evidences of active osteitis, bone destruction, or cholesteatoma must be absent.

3. A functional eustachian tube by Valsalva, Politzerization, or tubal catheterization test must be present.

4. An anterior rim of tympanic membrane sufficient to be visible is probably necessary. A posterior rim is not necessary; the perforation may be marginal here. In this case, the surgeon must be especially meticulous in the second stage of the operation to exclude the presence of a lurking cholesteatoma.

5. The ossicular chain must be intact, or reparable at the time of operation. This is the subject of the second in this series of articles. Briefly, it may be said that if the hearing loss is no greater than 30 db and the hypotympanum is open to the mesotympanum, the ossicular chain is probably intact. Patch testing is a simple and effective method of testing and has the additional advantage of dramatically demonstrating to the patient the rise in hearing. If the patch increases hearing, the chain is intact. If the patch decreases hearing the chain is disrupted. I find that siliconized tissue paper of the kind used for polishing glasses makes an excellent patch material. Pre-cut discs of different sizes can be kept at hand. The disc is moistened on one surface with an ear drop or ointment and may be facilely placed over the perforation with the use of a middle ear suction tip. Very large or marginal perforations cannot be patch tested because the information derived is not reliable.

Technique

The operation is performed under sterile conditions in the operating room. The canal, auricle, and adjacent skin is scrubbed with phisohex and the canal aspirated. Then the canal is filled with Betadyne and allowed to remain for ten minutes while draping is carried out and instruments arranged. Local anesthetic is used in the usual manner as for stapes mobilization.

1. The first step is debridement of the margin of the perforation to break the mucocutaneous bond at the margin of the perforation. This is best done while the tympanic membrane is tense, before flap elevation. Care must be exercised to remove that skin on the immediate inner margin of the edge; the skin grows over the edge to meet the non-advancing mucosal layer in rendering the perforation permanent. Atrophic areas of tympanic membrane without a fibrous middle layer are removed at the same time because these areas are without blood supply and participate poorly in healing. Special 90°, 45°, and 30° fine middle ear cupped forceps are used for this purpose.

2. A full-length posterior bony canal flap is then raised. The incisions form three sides of a rectangle, the two axial incisions each being slightly forward of the usual stapes mobilization flap and 1.5 mm. short of the annular rim, and the circumferential incision being just inside the verge of the bony canal. Elevation is carried out to the annulus and for a short distance anterior to proximal ends of the axial incisions. The annular ligament is elevated from its sulcus thus rendering the 1.5 mm. superior and inferior pedicles mobilized. The outer flap and posterior three-fifths of the tympanic membrane will depend for blood supply upon these tiny pedicles. It may seem incredible that this relatively large tissue mass can survive with ease with such narrow pedicles, but I have not seen an instance of flap or membrane necrosis. It is self-evident that other factors besides pedicle blood supply are operative here, probably among them are high diffusion penetrability in flaps of very small size, the optimum temperature and humidity of the depths of an orifice, and the immobility afforded by a bony chamber. The ossicular chain may now be inspected and the aditus examined for latent disease.

3. The canal flap is then advanced down the posterior canal wall which at the same time advances the posterior margin of the perforation anteriorly. If the perforation is relatively small the two edges may thus be brought together in slit-fashion and the approximated edges splinted with gelatin sponge. If the perforation is large, the posterior edge can be advanced past the handle of the malleus by dissecting the upper crescent of tympanic membrane off this ossicle which is a simple maneuver after the mucosa over the posterior face of the handle has been slit.

4. When the flap has been advanced to the limits of pedicle flexibility, which should close the perforation by no less than two-thirds, the remainder of the dehiscence is bridged with a free vein graft. The vein in area should be no less than twice the area to be bridged. If a large dorsal hand vein is not available, a segment of external jugular vein is used. Gelatin sponge discs, 5 mm. in diameter, are layered in the tympanum in rouleau-fashion, the tympanum is flooded with neomycin solution, and the advanced edge of the perforation brought to rest on the tym-

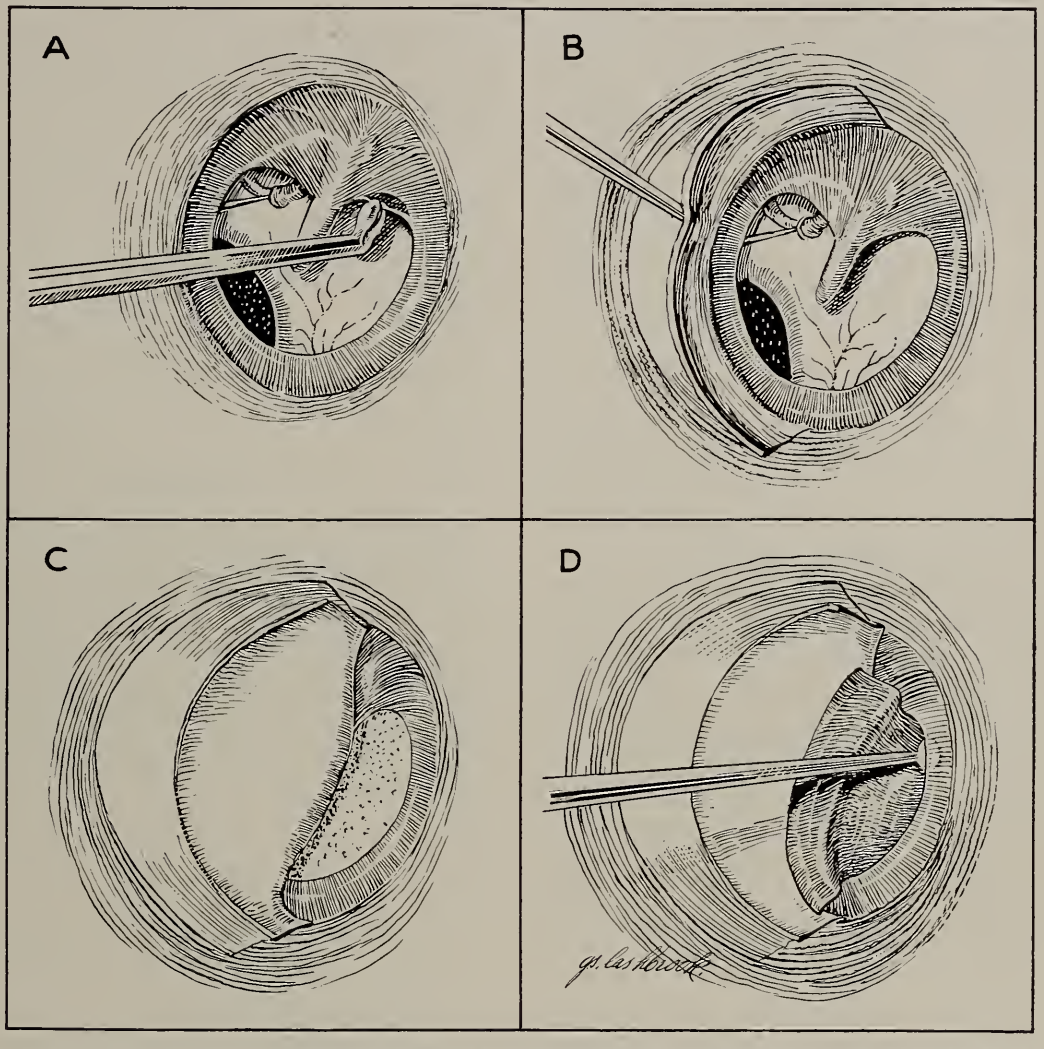


Fig. 2. Technique of bi-pedicle flap vein graft myringoplasty. The margins of the perforations are debrided (a) to break the mucocutaneous bond. Special forcepts angulated at 30,° 45°, and 90° are used for this purpose. A posterior canal flap (b) is elevated the full length of the bony canal from 5 o'clock to 1 o'clock with the axial incisions stopping 1.5 mm short of the annular ligament. These 1.5 mm pedicles will nourish the flap. With flap and pedicles mobilized, the flap is then slid down the canal wall (c) thus advancing the posterior margin of the perforation forward. A buttress of gelfoam discs in the tympanum holds the edges of the perforation in the same plane. If the perforation is not thus closed, a rectangular segment of vein is then tucked inside the edges of the perforation (d) all around to bridge the remaining gap.

panic buttress of gelatin sponge. The vein graft, intima-inward is then placed by tucking its edges underneath the perforation edges. As the gelatin swells, the vein is held securely in place against the inner aspect of the tympanic membrane. Increased blood supply will be afforded the graft if just prior to placement the mucosal layer at the perforation edges is scored many times with a sharp acutely angled hook. This frequently removes irregular shreds of epithelium, providing a wider area of contact between the fibrous layers of the two structures.

5. The outer surface of the composite is splinted with moist gelatin sponge discs, terminating the procedure. These outer discs are kept moist with antibiotic solution and not disturbed for four weeks.

Results

This procedure has been instrumental in my hands in the closure of nine perforations which may not have been closable by other methods because of their size. Four of these performations represented approximately four-fifths the total drumhead area. Each closure was attended by a rise in hearing in the patient. The improvements ranged from 10 db to 30 db and each was notable to the patient. Even the patient with a 10 db gain claimed significant improvement. All had relief of the hollow, stuffy, or "dead" feeling on that side of the head. Each ear has remained dry and without desquamation, and has required no aftercare subsequent to initial healing. The average stay in the hospital has been forty-eight hours, and the usual number of office visits five, over a six-month period. In two of the very large perforations, the patients operated upon subsequently suffered a delayed re-perforation, each in the area of the vein graft, but these were now small enough to be patched with silastic film until re-operation was convenient, with no interim limitations to the patient except restriction from high diving and skin diving which neither patient minded because neither cared for these sports.

Advantages

1. Large perforations can be closed in this manner with a better chance of success because the size of the free graft can be rendered materially smaller.

2. Perforations of a marginal nature posteriorly are amendable to closure by this method since a new posterior margin is created by the advancing flap.

3. Many dangers attendent upon closure of a posterior marginal perforation or any perforation are eliminated because upon elevation of the flap it is a simple and routine maneuver to remove enough annular bone to inspect the lower part of the ossicular chain for partial disruption and the aditus ad antrum for latent cholesteatoma.

4. Perforations of moderate or small size can frequently be closed with the use of the sliding bi-pedicle flap alone.

5. The canal skin is used to bridge the majority of the perforation. This material attains a thinness greater than any other cutaneum because it is already extremely thin, and has thus proportionately better acoustic properties.

6. With the exposure attained, it is possible to simultaneously repair a disrupted ossicular chain.

Summary

The use of a bi-pedicle full thickness canal flap and a vein graft may be attended by a high success rate in the closure of tympanic perforations. For many perforations it seems superior to any other method, especially for large and marginal perforations. No other method of closure gives the surgeon as much control over the auditory conductive apparatus as a whole.

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Homosexuality

A Medico-Legal Problem

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THE LAWS of Michigan and of most of the states reflect the ignorance and the superstitions of well-meaning legislators of 100 years ago. The rules and regulations governing traffic naturally had to change with the development of the automobile and the highways; regulations for aircraft are constantly being altered; public health measures show only a slight lag between scientific discoveries and legal readjustments.

Yet the laws concerning homosexuals have stayed far behind advances in the field of psychiatry and the field of education. Uninformed people express their fears and prejudices, and "act out" their own perfectly natural inhibitions against perverse sexual behavior; hence, such topics are laden with emotion, and no public figure wants to be associated with such topics, even if he be well-informed, because it is painful to challenge the prejudices of people. As a result, the judges, prosecuting attorneys, and lawyers are "on the spot" to enforce laws that go back to primitive attitudes, yet obviously are not in line with modern humane concepts and knowledge. The person with homosexual behavior—a maldevelopment of personality structure —is humiliated, an otherwise constructive career often wrecked, and society robbed of millions of dollars in police costs and loss of services of the convicted homosexual. It is high time that the public learn to tolerate the topic, to examine the facts and the most widely accepted theories, and to back a revision of the archaic laws. There need be no "cultural lag" in legislation, if we are willing to think through these issues and give moral support to the lawyers who are already preparing model codes in these areas.[1] Our own State of Michigan's report[4] of the Governor's Study Commission on the Deviated Criminal Sexual Offender is now ten years old and should be on the reading list of every serious citizen concerned with the persecution of otherwise law-abiding citizens.

Sources of Information

Reference has already been made to several recent publications, but it should be emphasized that numerous popular and technical studies are available, and indicate the concern shown by workers in diverse fields. Perhaps one of the best and most unimpeachable sources of especial interest to legislators, judges, prosecuting attorneys and lawyers, is the *Model Penal Code* constantly being reworked by the American Law Institute. The research abstracted by these men covers psychiatric literature, police statitistics, and many other sources of information and informed opinion. The recently published *American Handbook of Psychiatry* gives excellent coverage of the psychodynamics of sexual perversions, plus information on community problems and legal regulations. The Kinsey reports give us a view of the widespread nature of the problems, including statistics which indicate that half the adult population probably has experienced at least one homosexual relationship since childhood (which may explain why we have to act naïve about the problem). The psychiatric journals contain many articles of more technical nature, and Drs. Berg and Allen have devoted an entire book to *The Problem of Homosexuality*, including their analysis of the Wolfenden Report prepared in England in 1957.

Before going into a listing of recommendations and a discussion of what might be done, a few remarks can be directed to our own consciences. If we accept the prevalent understanding that the homosexual is

A statement from a study by the Mental Health Committee of Washtenaw County Medical Society. Dr. Mason is chairman of the committee.

The Council of the Michigan Society of Neurology and Psychiatry and the Michigan District Branch of the American Psychiatric Association gave their unqualified endorsement of this statement on September 29, 1960.

the hapless victim of a maldevelopment of personality structure, it follows that we must provide maximal opportunities for his readaptation. This is no plea to absolve the homosexual from any moral responsibility; it is a plea only to define his responsibility. A patient with tuberculosis has a responsibility to society *because* of his disease, but certainly does not merit legal and social annihilation. A person with normal heterosexual desires is morally obligated to discharge his sexual tensions in appropriate ways. A homosexual who discharges his tensions is similarly obligated to do so in ways which are harmless to others. Then, we must ask, what "living space" and what regulation is right for the homosexual? Are homosexuals dangerous? When? Are they "bad" people? Do they have any rights? How clearly does society face the fact that at present they are branded, despised, blackmailed, and persecuted? Would "a liberal attitude" and "tolerance" lead to an increase in the incidence of homosexuality, or of crimes associated in the public mind with homosexual fixation?

New Concepts

We cannot answer all the questions we have raised, but we can express in condensed form the modern views of people working in allied areas. An important starting point is expressed in the views of the Reporters to the Advisory Committee of American Law Institute (Model Penal Code, p. 277 ff), who believe that consensual relations between adults should be excluded from criminal punishment:

> Our proposal to exclude from the criminal law all sexual practices not involving force, adult corruption of minors, or public offense is based on the following grounds. No harm to the secular interests of the community is involved in atypical sex practice in private between consenting adult partners. This area of private morals is the distinctive concern of spiritual authorities. It has been so recognized in a recent report by a group of Anglican clergy. . . .
>
> As in the case of illicit heterosexual relations, existing law is substantially unenforced, and there is no present prospect of real enforcement except against cases of violence, corruption of minors, and public solicitation. Statutes that go beyond that permit capricious selection of a very few cases for prosecution and serve primarily the interest of blackmailers. Existence of the criminal threat probably deters some people from seeking psychiatric or other assistance for their emotional problems; certainly conviction and imprisonment are not conducive to cures. Further, there is the fundamental question of the protection to which every individual is entitled against state interference in his personal affairs when he is not hurting others. . . .

Since perverse sexual practices are symptoms of underlying pathology, a concise answer cannot be given concerning the "dangerousness" of homosexuals as a group. Only by a painstaking and thorough evaluation of each homosexual can the personality problems and potentialities for harm be assessed. But, by and large, overt homosexuals are (otherwise) well-behaved, law-abiding and productive citizens. The shocking "sex crimes" typically involve psychotic, predominantly schizophrenic, individuals who in the process of deterioration may show all sorts of unusual sexual aberrations as they regress through childhood levels of behavior. Such people are not picked up by the usual police techniques of luring overt homosexuals by various forms of solicitation in the public toilets. The very existence of punitive legislation and "vice squads" has exposed otherwise law-abiding citizens to blackmail and criminal attacks (i.e., "rolling"), and public exposure frequently leads to loss of jobs and to suicide. The book by Berg and Allen[3] gives many specific illustrations of these untoward effects of prosecution.

One psychodynamic pattern of behavior should be mentioned here, as of especial concern to the problem of law-enforcement personnel: that is the mechanism of "reaction formation." A child is often shamed into leaving one level of childish behavior in favor of a more mature way of acting, by doing just the opposite of the original bit of behavior. Most mothers, for example, are aware of infants' interest in the process and products of excretion. An undue emotional stress on this behavior may result in a "reaction formation" wherein the child becomes fastidious, "too clean," "clean with a vengeance," and disturbingly tense in situations where dirt and disorder naturally prevail. The fervor to be clean contains in it the energy of the previous inclination to be dirty—and the behavior now contains an *excessively emotional* attitude (instead of a *calm rational* attitude) which interferes with normal life patterns of behavior. Saul, persecuting the Christians prior to his conversion, is perhaps the most popular example of a reaction formation. Analogously, psychiatrists find that many highly promiscuous people, and many who vigorously condemn sexual perversions, are similarly reacting in a highly emotional and unreasonable way to deny—to themselves and to the world—their difficulty in leaving the childhood phase of development that involved "normal" impulses which, if unresolved, lead to homosexual behavior. It is a matter of common observation that the worst condemnations and most vigorous prosecutions of homosexuals involve "vigilantes" of questionable emotional maturity. It is with great wisdom that the Canadian Army regulations require that soldiers caught violating regulations against homo-

sexuality be referred automatically to medical channels for administration and supervision. Berg and Allen[3] (p. 159) state:

> The only proper approach to this problem is knowledge—knowledge of the facts and understanding. Emotional reactions are morbid symptoms whether they manifest themselves in the positive acts of perversions, such as homosexuality, or in the reactive forms of rage and sadistic punishment *against* perversions and homosexuality. Both perversions and emotional reactions against them are symptoms. *Symptoms are not appropriate therapeutic agents, nor are they sound judgment.* (Italics theirs).

Tolerance towards homosexual behavior cannot be considered an inducement to increased homosexuality if modern theories of causation are correct; and, if it develops that the more archaic theories of inborn errors of body chemistry turn out to be correct, this will make even more untenable the idea that tolerance is a factor leading to increased homosexual behavior. Certainly, attempts to make rehabilitation possible must be carried out in an atmosphere of tolerance. Most psychiatrists believe, with experience to support the belief, that the removal of irrational, blind inhibitions in a given patient allows that person spontaneously to experience normal, basically "moral" ways of living, not based on excessive external pressures to behave in a certain way. Analogously, decreasing the stigma on tuberculosis has encouraged victims to seek treatment, has encouraged the research that is leading to the eradication of the disease, and has demonstrated once again that the natural self-interests of most people lead them to seek help when no stigma is attached.

The Role of Psychiatry

Psychiatry has four real, if overlapping, roles to play in the community, as regards the problem of homosexuality. In the first place, some homosexuals can obtain real cures through psychiatric therapy. While this percentage of cures is not high—for a number of reasons—enough homosexuals resolve their conflicts to make psychiatrists feel that our undertstanding of the psychology of these people is correct.

In the second place, psychiatric examination of homosexuals (in a sincerely non-punitive atmosphere) can serve to differentiate the overt, practicing homosexual from the disturbed, psychotic, or psychopathic character who needs some form of continuous or intermittent institutional control. That is, some diagnostic facilities should be brought into play whenever an adult disturbs the community by inappropriate public display of sexual behavior, the molestation of minors, or the use of force or intimidation to achieve sexual gratification.

In the third place, supportive treatment of the related emotional problems of some homosexuals provides them with relief and greater efficiency on the job. It is not unusual for one or both partners in a marriage involving one homosexual member to seek help for certain crises that arise from time to time, indirectly as a result of the homosexual behavior. For example, a female homosexual became extremely depressed on being jilted by her homosexual partner. She sought relief in alcohol, and made a superficial suicidal gesture to make the former partner "feel sorry"—much to the consternation of the husband and her children, who had no comprehension of the situation. Brief, supportive therapy helped to alleviate the family crisis, without in the least altering the homosexual tendencies of this woman.

Finally, the social acceptance of homosexuality as a by-product of civilization will enable psychiatrists and other professional workers to educate the public as more research justifies it, with the ultimate aim of prevention. As Berg and Allen state[3]

> . . . The homosexual is not just a man with a wicked or perverse wish to behave differently from others. He is not someone offered the loveliness of women and by sheer cussedness spurning it: he is ill in much the same way as a dwarf is ill—because he has never developed.

Recommendations

For the sake of brevity and clarity, the following succinctly-stated recommendations are suggested:

1. The laws of the state should be changed to conform more closely with the recommendation of the Reporters to the Advisory Committee of the American Law Institute, that all sexual practices not involving force, corruption of minors, or public offence, be excluded from the Criminal Law. More specifically this would mean:

 (a) any legal interference in the sexual activities between two adults, carried on by agreement, in privacy, is an invasion of the basic right of the individual;
 (b) sexual activities involving display distasteful to the public, or exposing children to such displays, should be prevented by law, and violators examined for appropriate corrective action;
 (c) any sexual act between an adult and a child, whether heterosexual or homosexual, should lead to appropriate legal restraint, treatment and/or punishment;
 (d) any sexual act involving force, coercion, or violence, should likewise lead to appropriate legal restraint, treatment and/or punishment.

2. The mental health facilities of the state should be so arranged that

(a) sexual offenders will be examined immediately by psychiatrists employed by the Department of Mental Health or any recognized court-appointed psychiatrist, for medical recommendations (final disposition by court decision);
(b) a program of supervision (analogous to probation) be evolved with the same mental health facilities, in order to provide follow-up protection from and guidance for chronic offenders and potentially anti-social characters;
(c) sexual offenders now incarcerated should be carefully screened by a board of review similar to those in the Armed Forces, with power to recommend to judicial authorities the most reasonable disposition in view of their personality structures and the needs of society;
(d) the plans include some arrangements whereby patients so handled will bear as much of the costs of their treatment and/or supervision as possible.

3. A panel of lawyers and psychiatrists should be established for full consideration of contested decisions—a "supreme court" of qualified legal and medical experts appointed by the Governor or some appropriate legislative body.

These recommendations of the panel have been put down in concise form in the interest of brevity and clarity. This is a complex topic with many ramifications and any action undertaken requires the expert knowledge of many groups, especially the judiciary, the legal profession, people dealing in social services, the penologists, criminologists and all law enforcement agencies. This is a plea for all citizens to look at this problem dispassionately and support constructive legislation for dealing with the problem of homosexuality.

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Some Studies on the Metabolism of Ethanol

An *in vitro* comparative study has been made of the utilization of acetate-1-C^{14} and ethanol-1-C^{14} by way of the citric acid cycle in liver homogenates and isolated liver cells from ethanol-treated and untreated rats. The results demonstrate that acetate is utilized more readily by livers of normal rats than by those of ethanol-treated animals. In contrast, ethanol is better utilized by livers of the treated than by the normal rats. Accordingly, it is suggested that an increased activity of some of the enzymes which lead to the formation of acetyl-CoA from ethanol could be a contributing factor.

Another series of experiments demonstrated that prolonged treatment of rats with alcohol results in a steady rise in the levels of alcohol dehydrogenase (ADH) and to a lesser extent, of acetaldehyde dehydrogenase (ACDH) in the liver, a change which apparently is independent of food consumption. It should be pointed out that the former is considered the rate limiting enzyme in the chain of alcohol oxidation. After the levels of both enzymes attain a maximum, there seems to be a gradual decline probably in proportion to the degree of hepatic damage induced by the continuous intake of alcohol. The withdrawal of ethanol after 20 weeks of administration was followed by a decrease in ADH levels to control values.

This study was further extended to the determination of the activities of ADH in the sera of alcohol-treated rats as well as to those of normal and alcoholic human subjects. An increase in the ADH levels in the alcohol-consuming groups over controls was observed although the absolute values of this enzyme were much less than those in the livers of rats.

Although the above-mentioned findings can at least explain tolerance to ethanol, it is not yet known whether these aberrations are a by-product of alcoholism or are factors actually conducive to the disease. Nonetheless, early withdrawal of alcohol from alcoholic patients before any serious damage has occurred in their livers could reduce the activity of ADH to pre-drinking levels, as was found in the present study on rats. Should future work reveal that the rise in the levels of enzymes, particularly ADH, is implicated in causing alcoholism in man, the present findings could be of great value in the understanding and perhaps the control of this disease.—Abstract of a paper presented by Rashid M. Dajani and James M. Orten, Department of Physiological Chemistry, Wayne State University College of Medicine, Detroit, before the Detroit Physiological Society, December 15, 1960.

Socialized Medicine

Two and three decades ago the profession objected to and fought at every opportunity every move leading toward compulsory health insurance which the bureaucrats advocated but which the medical profession recognized as socialized medicine.

For a number of years now the profession has been opposing what it called the Forand-type legislation under which, as was repeatedly stated during the election campaign and afterwards, that people aged 65 and over would get their medical and hospital care under social security. The bureaucrats and the advocates of these measures, including President Kennedy, insisted this was not socialized medicine. It was compulsory, it used your taxes and mine and those of everybody else who paid taxes to render special services or benefits to a selected group of people. That group was in involuntarily. That is certainly socialism. The Socialist party itself has stated many times this was its ambition, and it could increase these services in extent and amount of coverage and in the eligible age limits. Forand has admitted his Bill would be a foot in the door from which could be built complete compulsory medical care.

Last summer between the nominations and the election, the Congress made an effort to pass the Forand Bill, or one introduced by Senator Kennedy, and it failed. The Republicans proposed bills which met the opposition of the medical profession. However, Senator Kerr went to work with both groups and the Kerr-Mills Bill was evolved, under which the needy among the retired and over 65 citizens (whether under social security or not) could be cared for under certain specific regulations and under general taxes. This is a group of people who in all justice has a claim upon the general population for care and assistance. The beneficiaries of Social Security in the over 65 group, and those being automatically added to that group and granted health services, under the new HR 4222 would create a great tax injustice. Actually the vast majority would be getting benefits they could well pay for themselves and would be foisted upon a service which over the years had built up a special tax fund by compulsory taxation, anticipating benefits for their old age.

The Kerr-Mills Bill which the medical profession advocated was passed and put into effect in Michigan at just about the time of the election. It was anticipated there would be about 65,000 beneficiaries in Michigan.

The Act has been in effect now for four months or more and there have only been 8,300 applicants, just about 1/8 of the estimated number who would need this service. So far as the doctors can see there is no one suffering for lack of service. Of course over 235,000 of the estimated 600,000 persons over 65 are now covered by Blue Cross and Blue Shield. The Kerr-Mills Bill is effectively caring for the aging persons of meager incomes who need attention, as was

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requested by the House of Delegates of the American Medical Association about four or five years ago.

The Kerr-Mills Bill is private, individual medical care with patients selecting their doctors, and this service is paid for by a general tax as has been done for ages for this group, they being the natural responsibility of the general public.

Socialized Power and Light

The bureaucrats and the socially minded politicians are not resting with medicine in another move to introduce socialism into the United States. For many years we have had an example and a very outstanding one. The *Saturday Evening Post*, in its editorial of March 25, says:

"SOCIALISM WOULD BE A STRANGE EXPORT FOR THE U.S.A."

"In announcing the appointment of a new member of the board of the Tennessee Valley Authority, President Kennedy urged that organization to 'study ways in which the lessons it has learned in the Tennessee Valley may be exported abroad.' While few dispute the accomplishments of TVA as an engineering achievement, it would be less than accurate to send abroad the impression that only by tax-consuming, semi-socialistic projects have we taken 'long leaps forward!'"

The editorial comments that TVA has used the taxpayers' money and has accomplished great things but has made no return of taxes to the government. It says private power companies using their own and their stockholders money have made just as elaborate advancements in science while paying taxes. It cites Idaho Power Company, Hell's Canyon dams which paid $10,000,000 in Federal, state and local taxes last year. It wonders why the "capitalistic" United States should attempt to educate other countries on the virtues of socialism.

It is an interesting fact that the private independently owned power plants in Michigan, for instance, while making tremendous advances and helping develop two nuclear fission plants, not only has not used public funds, but Detroit Edison paid in Federal, state and local taxes, $54,512,895 and Consumers Power paid $42,809,704, or a grand total of over $97,000,000. In spite of this the Federal agitation constantly has been to set up more groups throughout the nation. This same threat now faces medicine. The bureaucrats and the socialistic planners have turned to the medical profession as much easier victims.

The experiences of the President's Conference on the Aging in January indicate to what extent these people will go to accomplish a purpose. They reported large numbers of groups who voted to put the care of the aged under Social Security. Those figures were not true and have been exposed numerous times. The group voting on that particular item had only one doctor in it, but did have bureaucrats and dedicated labor representatives who absolutely buried a minority report and issued a report favoring the social security angle.

This Matter of Living

Here in Michigan, the medical profession has one measure opposing socialization of medicine. In the 1930's it developed its Blue Cross and Blue Shield program. This was not a perfect organization but it was a working one and it could and did care for the lower income and middle income groups with very little complaint. The higher income groups (over limit groups) in some instances had disagreements. That need not have been.

For years and throughout the course of pre-paid medical services, the Michigan State Medical Society has advocated that doctors and patients talk over their fees before service is rendered, or at the time it is rendered and have an understanding as to extra charges. Had that been done there would have been very little dissatisfaction.

Now we are passing through another era. For some reason, for the past five years, the insurance department has kept Medical Service working in the red with inadequate rates to carry the load. The Blue Shield contracts provide for very special services needed in many of the newer procedures which were unknown half a dozen years ago. Naturally costs have gone up, yet every time there is a request for increased adjustment, we have had a publicity blast.

The Medical Society and Medical Service has had unfair criticism from newspapers, bureaucrats, from critics all over with very unfavorable publicity. Most admit proper work is being done satisfactorily, but it is a chance to criticize—not the individual doctors—but the group. A feeling and a tension has been building up which adds to the recently developing general drive for socialization. The leaders of the profession, national and state, believe we have never faced a more serious or more threatening time than right now.

Another Bill (HR 4222), was introduced as a substitute for the Forand and others, on February 13, 1961, by Congressman King of California. This is very definitely socialized medicine. It provides for compulsory care and amends the Social Security Act to provide health benefits for the aged.

This new "Health Insurance Benefit Act of 1961" (HR 4222), expressing the program of the Administration, is shrewdly written, and vicious. It specifically denies being socialized medicine. It has a section prohibiting any department or official from dominating or in any way influencing or suggesting medical actions. It gives hospital and other benefits, but gives the pa-

tient full choice in selecting his own hospital or *doctor* and specifies that no medical or surgical benefits are given—attempting to avoid the charge of socialized medicine because it is not medical or surgical and makes no provision to pay such. It specifically excludes medical or surgical services provided by a physician, resident or intern except in the field of pathology, radiology, physiatry or anesthesiology. . . .

This is very cleverly drafted to disavow socialized medicine and interference. But hospital services must be under a physician and his orders. Also the pathologists, radiologists, physiatrists and anesthesiologists are physicians.

This Bill was written to misinform the public in the belief it does not involve physicians, and also the older people who have been led to believe medical care for their older years was promised.

The American Medical Association called a special conference with representatives from every state who met in Chicago, March 18-19, to consider this Bill. The general opinion was that if this Bill should become law—as it very seriously threatens to do—that would be the end of the private practice of medicine in the United States. Doctors are now working under very favorable conditions with the insurance principle and pre-payment paying a large percentage of their bills. Blue Cross and Blue Shield alone cover nearly 50% and there are thousands of private insurance companies carrying this service too. It is estimated that nearly 80% of our total population and of the retirement age group now have some form of prepaid health insurance.

This proposed King-Anderson Bill (HR 4222) would immediately take over everybody over 65, who's under the Social Security system, the blind, the dependent, the handicapped. Passing this Bill would breach the barrier now in force against compulsory health insurance by putting 15 to 20 million people in it. What would prevent an ambitious person wanting votes to change that limit to 60 years, or 50 years, or 35 and then ultimately to wipe it out completely.

That is the foot in the door about which medical leaders nationally and locally are very seriously concerned.

Special House of Delegates Session

The Council of the Michigan State Medical Society at an emergency meeting held March 26 in Lansing, considered the impending problems and voted unanimously to request the Speaker to call a special session of the House of Delegates of the Michigan State Medical Society.

These special sessions have been held at rare intervals, but never for a more far reaching and impelling reason than the problems facing Michigan Medicine today. The special session of April 16, 1961, will be history by the time this editorial reaches our readers. The advice and counsel at that special session will then be in the process of implementation. The socialized medicine threat demands constant observation, but now as a corollary to opposing and fighting these particular measures, we invite attention to the Blue Cross and Blue Shield programs which staved off this threat 20 years ago. The united determined support from our membership will again help us. Within the last few months we have placed into effect and made available throughout the United States, another enactment which could demonstrate to the public that the social security method of compulsory care is not necessary.

McNerney Report

In this issue of THE JOURNAL, we are publishing a McNerney report. This is almost a duplication of a speech given by Professor McNerney to The Council and the Conference of Public Relations and County Officers on January 29, in Lansing. Until now, the professor has refused to give anything in writing which could be published. This material was received on March 20 and immediately rushed for emergency setting and publication.

The Publication Committee and the Editor believe this material is so vitally important, especially in this time of stress, uncertainty and impending difficulties, that every member should have an opportunity to read this whole report. It contains basic information from a five-year study. It points out what could happen to the private practice of medicine, what the doctors must do to avoid that condition and how they can preserve the right to practice medicine as individual citizens.

We urge our members to read this whole article, not once—but twice, and consider seriously his own individual reaction. We appreciate that many of our doctors do not believe the stories of the threat of socialism, but our pioneers, our administrators, nationally, state wide and locally, appreciate that a very desperate change is in the making, unless we are able to re-establish the happy confidence of our patients in the true significance and implication and accomplishments American medicine has made in the last generation, and especially in the last five years.

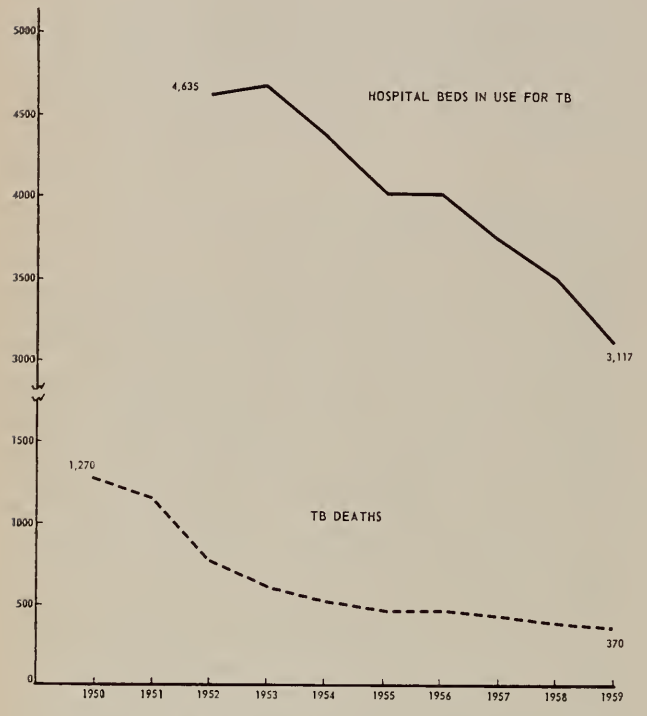
Please read the article. Not with resentment, but as the considered recommendation of the group of devoted investigators who have studied the medical profession of Michigan for nearly five years.

We hope the final report will be available soon, but until then, this is what we have.

Guest Editorials

An Old Pattern for New Progress

A few hundred meetings ago, one of our distinguished colleagues asserted that the way things were going, we wouldn't conquer tuberculosis in a thousand years. At that time, patients were waiting for sanatorium beds, and the see-saw record of tuberculosis cases showed apparently little reason for optimism.



Emphasis on early diagnosis, prompt and modern treatment, and rehabilitation have helped bring about this dramatic progress against tuberculosis. Along with the cut in deaths and the declining need for hospital beds, the total number of new tuberculosis cases reported yearly (both active and inactive) has dropped from 5,538 in 1950 to 4,743 in 1959.

Fortunately, the thousand-year prophecy was not unalterable. Some perserverence, with more than a dash of statesmanship, has paid off. Not that we've finished with tuberculosis, but we have made immense progress and can take much satisfaction in what has been done. More important, we can take from this experience some good tactics for use in other places. Particularly, we can apply what we have learned in tuberculosis to deal more effectively with other chronic diseases and mental illness. We can use the old pattern for new progress.

A LOOK AT TUBERCULOSIS TODAY shows a sharp reduction in deaths, a significant reduction in cases, and a declining need for tuberculosis hospital beds. Some local sanatoriums have been converted to use as general hospitals or for chronic disease patients. Mental patients have been admitted to state sanatoriums. And we are in the process of trying to work out the transfer of the Michigan State Sanatorium at Howell to the Department of Mental Health. This continuing advance was brought about by a working partnership of private medicine, official public health and voluntary agencies in a three-pronged attack. We said:

1. Let's work together for the early diagnosis of tuberculosis.
2. Let's insist on prompt and modern treatment.
3. Let's help the patient get back on his feet with rehabilitation.

As many readers of THE JOURNAL MSMS know, it is seldom easy going, making those three things work, but the results speak for themselves.

IN CONTRAST WITH TUBERCULOSIS, our situation with chronic diseases and mental illness is characterized by long periods of disability and hospitalization, the continuing upward spiral of hospital care costs, and the demand for more and more facilities. There is currently a backlog of 79 Michigan hospital construction projects which would cost $125 million and are eligible for Federal Hill-Burton matching funds, if we had the money. There are increasing demands for nursing home beds and the well-advertised waiting list at mental institutions. Private and public health practitioners alike have an opporunity, if not an obligation, to try to establish in these fields the same concepts employed in tuberculosis.

In govermnent programs touching these fields, let us, together, strive to establish a high priority for early diagnosis. A case in point: the possibilities for public screening programs for diseases such as diabetes and glaucoma. Let us, together, strive to develop care which is not only most effective but also most economical. Here we might well ask how we can act most expeditiously to supplement Michigan's first class hospital care with first class home nursing care, not only in areas where these services already have been started, but also in the sixty counties of the state which virtually have no such service available. Let us, together, give the techniques of rehabilitation something more than lip service. We can no longer afford the luxury of warehouse storage for the patient who might be put back on his feet by proper treatment in a quality nursing home or in a rehabilitation unit.

BESIDES ADVANTAGES IN HEALTH AND ECONOMY, this approach would reinforce private practice. As familiar examples, there is the screening program which can reach the woman with unsuspected cervical cancer in time for early diagnosis and suc-

cessful surgery, the visiting nurse who can assist the amputee in learning to hobble around on his new prosthesis, and the physical therapist who can help save the coronary patient from vegetating in a nursing home bed. Building the concepts of early diagnosis, prompt and modern care, and rehabilitation into government health services thus augurs well both for the practice of medicine and for the health and pocketbooks of the people. The gain can be made only with the energetic leadership of the doctors of Michigan.

ALBERT E. HEUSTIS, M.D., M.P.H.
State Health Commissioner

Our Largest Disease Syndrome

Human nature plus alcohol and sales promotion causes our largest disease syndrome, including physical and mental disease, premature death, delinquency, crime, broken homes, mental anguish, poverty, and reduced national vitality.

The American Medical Association states, "Chronic Alcoholism in the United States has reached the alarming degree where it directly affects about 20 million people, who are the families of alcoholic patients, estimated at almost 5 million. Indirectly, every man, woman, and child in the United States is affected sociologically, psychologically, and economically by this problem," . . . and . . . "This offers to the medical profession a challenge it cannot ignore."

The acute problem drinkers increase those directly affected to 40 million, or one alcoholic in every 4½ homes. It costs State government $5.00 for every $1.00 received in liquor revenue. $1.00 comes out of every $25.00 of wages, or 16 billion, or one-third the national defense.

One state reports 20 per cent in its mental institutions are alcoholic. No state can provide enough mental hospitals at $20,000 per bed for construction alone. At Michigan Southern Prison, the largest in the world, 49 per cent are alcoholic, and 10 per cent drug addicts. Who all constitute the accomplices to this 49 per cent?

One and one-half million crimes in the United States in 1958 were up 9.3 per cent over 1957. Of the 10 per cent crime increase among youth under eighteen, 81 per cent were for driving while intoxicated. Population increase was 1.7 per cent during the same period. Death on highways was 50 per cent alcohol connected. In 75 per cent blood tests were demanded. For each death, there were 106 injured.

The University of Michigan reports: "In terms of conduct, drinking is the number one problem of higher education in regard to the individual and his group."

March 29, 1961: Troops called out at Bowling Green State University. Student demands include relaxation of bans on drinking on or off campus.

Hillsdale College: Friend kills friend after day with beer.

Being a habit-forming narcotic, alcohol is automatically propagated in addition to advertising and sales pressure of all kinds by all who profit from it, so now 75 per cent of Americans drink beginning in high school, producing over 1000 new chronic or acute problem drinkers daily in comparison with 20 cases of polio under disease prevention.

The AMA carries no liquor advertising in its extensive publications for obvious reasons.

Liberty to drink under the law is one thing, but liberty for money, to persuade youngsters during the years when conformity is natural and one out of fifteen becomes a chronic alcoholic, is something else.

During World War II, there was great concern over the physical unfitness of recruits. Our government has just appointed an athletic director and football coach as special consultant for a National Youth Fitness Program, while it allows the alcohol interests to sponsor TV and radio sports programs.

Alcohol subverts the mind and damages brain and body tissue. We would remonstrate with action if a foreign nation sabotaged our man power. No American wants this.

If prohibition established today could really prohibit, one million people could shortly go into convulsion, coma, and death. Alcoholics want to get well. They suffer terribly. Education, understanding, and treatment, together with elimination of all types of advertising is needed. America wants disease prevention.

The AMA has stated the problem. We know the method and our duty to join with the courts, penal institutions, industry, labor, education, government, and others to reduce this disease.

Silence by the major political parties on this subject negates their efforts at health, education, welfare, and disease prevention.

Slavery of 100 years ago built mansions for some and hovels for many. Millions are now under bondage to alcoholism.

Massive information directly to the people by the health professions regarding this growing national catastrophe would raise the hopes of the millions of Americans directly affected, and the appreciation of the whole nation.

RALPH H. PINO, M.D.

Report of Speaker of the House of Delegates to The Council

Special Session of the MSMS House of Delegates, Sunday, April 16, 1961, at Kellogg Center, Michigan State University, East Lansing

On subject date the House of Delegates of MSMS convened in special session for the purpose of discussing implications of H.R. 4222 in the Federal Congress which proposes health services to the aged through the Social Security system, and to develop and implement a necessary informational campaign to the public through MSMS members. Seven work groups discussed these matters. Following are the official reports of the work groups as adopted by the House of Delegates in plenary session:

Reports of Work Groups

I. "Financing the Program"

"This workshop committee was furnished information regarding the monies available for this program in a communication from Dr. O. B. McGillicuddy, Chairman of the Finance Committee of The Council. A total amount of $6,450.00 is already in three Public Relations accounts, with an additional $35,000.00 in a Public Relations reserve presently invested in Government Bonds. The General Reserve fund of the Society amounts to $22,000.00 and must be maintained in reserve for extreme emergencies only.

"It should be pointed out that this is a long-range program of many years' duration and that the timing of our maximum effort cannot be predicted at the present time. The proposed 12-month budget submitted by Mr. Brenneman of which you have received a copy requests an outlay of $24,450.00. This budget was reviewed with Mr. Brenneman and your Committee does not recommend any change in the listed items. It was the consensus of the Committee that the financing of this continued program would without doubt be reconsidered by this House of Delegates at their regular Annual Session in September, 1961.

"This Workshop recommends (1) that the proposed plan of action as submitted by Dr. Engelke this morning be approved; (2) that $10,000.00 be made available for the remainder of this fiscal year ending November 30, 1961; and (3) that The Council be authorized to allot additional monies from funds presently available in case of an emergency need in carrying out this program. Mr. Speaker, J. M. Wellman, M.D., Chairman, *moves* the adoption of this report."

The motion was seconded by Charles W. Oakes, M.D., and unanimously *carried.*

II. "Communicating with Doctors"

"Mr. Speaker and Delegates, as a result of our Workshop discussion and study, the following recommendations are made regarding communicating with doctors:

"1. Mailings to all MSMS members: the workshop participants recommend that all mailings should be as brief as possible and printed for greater legibility. It recommends that an initial letter be sent which would give basic current information. Subsequent mailings would provide periodic up-dating of information and status of legislation. Strongly recommended was the establishment of a set of addressograph plates for each physician's home so that information could be sent to doctor and his wife. It was felt that this would accomplish two purposes—contact the important Auxiliary member and permit the physician to review material outside busy office hours. It was agreed that these plates should not be used by any group other than MSMS. It was felt that over a 12-month period, three mailings to all MSMS members would be necessary.

"2. Mailings to Campaign for Freedom Chairman and committees: the workshop agreed that this established list of interested doctors might serve as a nucleus of physicians who would desire to be informed to a greater degree than all MSMS members. These physicians were appointed by all county medical societies in 1960. If MSMS found it necessary to get information out quickly, this list of physicians could be contacted by telegram and then relay message on request by person to person contact. It was agreed that over a 12-month period, six mailings might be necessary.

"3. Preparation of printed bulletins for reading by the Secretary and/or distribution to physicians attending county medical society meetings: the workshop participants recommend that these bulletins be prepared periodically. It was believed that this distribution method would be effective and economical.

"4. Press releases to county medical society publi-

cations: since a majority of physicians are members of county medical societies which publish a bulletin, this workshop urges that regular press releases be sent to editors to augment information appearing in publications of MSMS and AMA.

"5. Contact through hospital staffs: it was recommended that information be disseminated through chiefs of hospital staffs, especially in more highly populated counties. Specifically, that hospital staff meetings be utilized as a forum for discussion and brief informational reports.

"6. Mailings to legislative report list: the workshop recommends that this group of approximately 600 continue to receive special legislative information throughout the year.

"7. Contact with delegates: it is recommended that the MSMS consider this a key contact group to receive detailed information and keep them constantly informed of current status of national legislation. This group should be an important action group. Delegates should be included in all mailings to Campaign for Freedom chairmen and committees.

"8. Regional legislative conferences: the workshop believes that person to person contact is essential to a successful information campaign and recommends that legislative conferences be held.

"9. Speakers Bureau: one-day training sessions: the workshop believes it highly desirable to hold a one-day training seminar to bring together speech experts and physicians who desire to improve their speaking abilities. Several speeches on different aspects of the problem should be distributed. County medical societies should be urged to enlarge their speakers bureau. Mr. Speaker, R. Wallace Teed, M.D., Chairman, *moves* the adoption of this report." The motion was seconded by Charles W. Sellers, M.D., and unanimously *carried*.

III. "County Medical Society Programs"

"The County Society as an organization stands between the State Society Officers and the grass roots or individual physicians. The County Society is sensitive to local feelings, and is therefore in an ideal position to interpret a general campaign to the local citizens. Secondly, the county society must be the body that checks up on the individual physician, on the good doctor who ignores political facts, and the bad doctor who gives medicine a terrible handicap by overcharging.

"Your committee believes that the county society must organize local action; interpret to and educate each physician, and constantly inspire and drive him to active participation in this campaign. There is no one else to insure that each member does his part.

"Your committee favors the expectation that each physician deliberately plan and intend to discuss the facts with at least one patient daily, and to devote at least one hour weekly to promoting our campaign by correspondence or other means. Toward this, our able Vice Speaker suggests the slogan: 'One Hour a Week For Freedom.'

"A big sore in medical public relations is the variation in financial charges among different physicians and communities. Our attack against socialized medicine would be aided if we could develop an improved public image by developing a satisfactory solution of this problem. One method would be for members to have an advance financial understanding with each patient. Your committee finds some lack of full understanding of the workings of the Kerr-Mills Bill, and believes there is a need for further education of physicians and county aid officials on that subject.

"Your committee recommends that each county society promote and fully support its Womans' Auxiliary, for they can be of inestimable value and true auxiliaries, in promoting our campaign among the citizens, and in educating the public. The same support should be given similarly to Medical Assistants Societies.

"Mr. Speaker and delegates, as a result of our workshop discussion and study, the following recommendations are made regarding county medical society programs:

"1. Regional conference: in order to inform and inspire county society leaders and officers, we recommend that The Council organize four regional conferences to be held as soon as possible, on a Sunday. One would cover the Councilor Districts of the Detroit metropolitan area, one the lower portion of the Lower Peninsula, one the rest of the Lower Peninsula, and the fourth the Upper Peninsula. Those invited should include delegates and alternates, councilors, county society officers and board, PR officers and other appropriate officers. MAP officials could well be invited as guests.

"2. Report on special House of Delegates session to county societies: your committee recommends that each delegate report at the earliest opportunity the facts and spirit and importance of this meeting today. Each county group of delegates should determine the most effective method of informing their officers and members. To aid this, the state society office should send to each delegate and to county society officers a report of this meeting. We recommend that Dr. Drolett be asked to put the outstanding talk that he gave to us this morning on tape so that it can be used at county society meetings and possibly other meetings. Many small societies lack inspiring speakers; this would help fill the vacuum. We also commend this talk for reproduction for mailing to each M.D. in the state.

"3. *Exchange of Ideas Newsletter* to C.M.S. officers: an *Exchange of Ideas Newsletter* for mutual interchange of ideas between county society officers would be of value, provided that function is not covered by existing publications. It would require active co-operation by county officers to be of value.

"4. County society bulletins: we recommend that county society bulletins devote a good share, perhaps a third, in each issue to material aiding this campaign.

"5. Neighborhood coffee meetings: your committee supports the proposal for coffee meetings of neighborhood wives and friends. Literature and other aids should be made available for these meetings.

"6. Local newspaper ads: your committee supports the placing in local newspapers of the advertisement which the AMA will place in metropolitan papers.

Mr. Speaker, Don Marshall, M.D., Chairman, *moves* the adoption of this report."

The motion was seconded by Jacob F. Wenzel, M.D., and unanimously *carried.*

IV. "Media"

"It was felt that the function of this workshop on Media was to develop methods of reaching the people of the State of Michigan and to inform them of the contents and implications of the King-Anderson Bill, and the positive and preferred aspects of Medicine's program. The media channels considered by this committee consisted of the following: (1) press; (2) radio; (3) television; and (4) doctor-patient communication.

"It was the consensus of the committee that the most important and effective channels to the general public were the press, and doctor-patient communications.

"In pursuance of these aims, the following resolutions were favorably considered and are recommended for submission to the House of Delegates for approval:

"1. RESOLVED, that press relations should primarily be the responsibility of a public relations or press committee of each county medical society. Where publications are on a state-wide basis, however, the responsibility should be shared by the Public Relations Committee of MSMS. Every county medical society which does not at present have a PR or press committee should be urged to create one forthwith. The following techniques, with regard to press relationship were suggested for use by the county medical societies: (A) development of personal contact between appropriate members of the society and local editors, in order to present medicine's position and to enlist favorable editorial support; (B) sponsorship by each county medical society of advertisements on local newspapers such as those proposed by the Communications Division of AMA; (C) enlisting of support of local representatives of the National Retail Association and Chamber of Commerce in strengthening liaison with the press; (D) encouragement of letters from non-medical personnel to the editors, to support medicine's position; (E) publication of articles in special interest newspapers and magazines such as local shopping news, organization publications, etc.

"2. RESOLVED, that the media of radio and television be under the direction of the MSMS Public Relations Committee and that the utilization of radio and TV time and audio-visual media should be determined by this committee.

"3. RESOLVED, that doctor-patient communications be implemented with a poster bearing appropriate information concerning the King-Anderson Bill, together with an invitation to the patient to discuss this matter with his physician, and that this poster be distributed to every member of the MSMS for display in his office.

"4. RESOLVED, that a revised pamphlet be prepared by MSMS which emphasizes the positive aspect of the Kerr-Mills Act, and which exposes the dangers inherent in the socialized medicine King-Anderson Bill (HR 4222).

"And be it further resolved, that information from AMA publications, along with information applicable particularly to Michigan should be incorporated into a single pamphlet; and be it further resolved, that the above mentioned poster be equipped with a box to contain the proposed pamphlet.

"The media committee took under advisement a resolution submitted by Dr. Charles Sellers which implied financing of the cost of newspaper publicity. No action was taken on this resolution because this matter was thought to be more appropriate for consideration by the special committee entitled 'Financing the Program.' Mr. Speaker, Jack Rom, M.D., Chairman, *moves* the adoption of this report."

The motion was seconded by J. Leonidas Leach, M.D. and unanimously *carried.*

V. "Legislative Contacts"

"Mr. Speaker and delegates, as a result of our workshop discussion and study, the following recommendations are made regarding legislative contacts:

"1. Committee of 10 per cent program as in Campaign for Freedom to obtain letters to Congressmen: we recommend the re-establishment of the technique of 'Committees of 10 per cent' and further recommend the extension of this technique to hospitals, medical, nursing and pharmacy schools, and other ancillary groups.

"2. Washington, D. C. trip to Congressmen's offices: in addition to endorsing the MSMS trip to

Washington, D. C., we recommend that county medical societies send groups to Washington for personal contact with Congressmen, that individual physicians (and their friends) be urged to visit their Congressmen while in Washington, and that such contacts explain medicine's stand against socialism (and HR 4222 in particular) and stress medicine's positive program for the care of the aged and the American people generally, and that all this be done in a diplomatic atmosphere as opposed to one of controversy.

"3. Petitioning of Congressmen, from CMS and others, by formal resolutions: We recommend encouragement of county medical society resolutions, and further recommend that county medical societies urge allied professional groups, chambers of commerce, farm bureaus, etc., to also petition Congressmen in support of our position.

"4. CMS meetings with legislators at home: we recommend that informal meetings (as opposed to formal county medical society meetings) be conducted for the purpose of meeting with both state and national legislators so that they and physicians can better understand each other's problems and views.

"5. Activation of list of personal physicians of Congressmen: we disapprove of this technique.

"6. We recommend that in all legislative contacts, by whatever technique, physicians observe certain protocols, including in particular:

(A) Be positive, and stress what you are for (Kerr-Mills Bill);
(B) Be friendly, not critical or antagonistic;
(C) Be concerned, with the effect of socialism on your patients as citizens of a free nation;
(D) Be proud, that medicine has made more progress in our American atmosphere of freedom than anywhere else in the world;
(E) Be certain, that socialism once started can never be stopped and eventually results in ruinous taxation.

Mr. Speaker, John G. Slevin, M.D., Chairman, *moves* adoption of this report." The motion was seconded by Vernon V. Bass, M.D., and unanimously *carried.*

VI. "Working with Others"

"Mr. Speaker and delegates, as a result of our workshop discussion and study, the following recommendations are made regarding working with others: our workshop had a most stimulating and I think fruitful discussion on this subject. Our report may not include many of the basic ideas that need further exploration and discussion. In general, we said 'yes' to the suggestions made on the Presidents Program, but decided that mailings to individual groups or contacts in meetings of representatives ought to be made by the medical profession with a much firmer and a more concise concept of the subject. Therefore, we talked about (1) defining what we are for, and (2) defining what we are against. We think it important that we prepare and state simply in as few words as possible an outline of these objectives so that we will have a uniform 'battle cry.' This 'battle cry' can then be tailored for presentation to an individual, to a small group, or to a mass audience, as in the suggested mailings. Both a capsule presentation and a formal address ought to be formulated. We have agreed that multiple key words and phrases ought to be included, such as 'the subject which we are against has Communistic approval,' that 'Social Security represents a tax,' and that 'a basic problem with our communication with others is a lack of understanding of the doctor's philosophy.' We feel that the most receptive audiences for our message would include: service clubs, chambers of commerce, church groups, PTAs, college level groups, MEAs, medical students, boy scout and Y groups, your own kids, and your wife.

"1. Establishment of editorial contact list: we reviewed and accept the AMA pamphlet of editorial material and we urge their 'personal' distribution to editors of your community news media. These might include not only your daily or weekly papers but fraternal, church and trade publications.

"2. Statewide meeting with ancillary and interested groups, and arranging for speakers via a statewide speakers bureau: believing that increased federal control is our greatest danger to the preservation of our civil rights, we therefore propose meetings of all ancillary and interested groups with similar problems for discussion, formulation, and concerted plans for integrated action. Establishment of a state speakers bureau and a complementary speakers bureau at either a county or a councilor district level, will be the key to the success of these meetings. The delegate should remember, however, that each physician is a speaker in his own right and to his own patients of the aims and desires of this program. For example, in counteracting the approval of the National Council of Churches of the King-Anderson Bill, it would be well for each doctor to personally visit his own minister or priest or rabbi, prepared to discuss or answer questions concerning this program. This discussion group feels that it is a lack of information, or a misinterpretation of the facts, that has led the national organization to approve such a measure. By attacking it at a local personal level, clarification of the issue could be accomplished and the simultaneous contact of representatives at a state level, with the Michigan Council of Churches, would be a progressive step towards them publicly reversing their decision. This same example could be utilized with farm groups, chambers of commerce, or professional groups that are experiencing

the same loss of individual decision and rights exerted by the growing federal power.

"3. Woman's auxiliary, medical assistants, Michigan Health Council list, Michigan Association of the Professions membership and Health Insurance Council: we heartily approve the use of the facilities of the above in the mailing of material to these organizations. Attention should be drawn to the cards on your desks publicizing the Michigan Health Council State Conference on May 23-24-25. This meeting is appropriately timed and will include representatives of all these interested organizations. This is a most opportune occasion for us to clearly delineate this program's objectives. We are fortunate in that Dr. Annis, as the banquet speaker, will amplify our theme. Any of the delegates who have 'hard to convince' individuals in responsible positions of groups that are adverse to our program could be brought as guests to this meeting, which is open to the general public. I think that the main idea that evolved from our discussion group is that the Society state clearly its program's objectives. Effort made to arrive at these clearly stated objectives will be of the greatest use to its speakers, its mailing programs, and its members at large. We want to thank all of the delegates and guests who participated in the discussion, and in particular Drs. Paul Ivkovich, Dave Bowman and our Councilor Jim Dehlin. Mr. Speaker, James D. Fryfogle, M.D., Chairman, *moves* adoption of this report."

The motion was seconded by A. Carl Stander, M.D., and unanimously *carried*.

VII. "Establishment of Position and Policy of Michigan Medicine"

"RESOLVED, that the House of Delegates of the Michigan State Medical Society meeting in special session mobilize its full resources and call upon *every physician* and constituent and component medical societies to:

"1. Continue to *provide the world's highest quality of medical care* to all our citizens;

"2. Impress upon the citizens of Michigan that the responsibility for financing one's own medical care rests first with the individual, then his family, community, county, state, and only if these should prove inadequate and *as a last resort* the Federal government;

"3. Assist all *who need help* in meeting the cost of medical care;

"4. *Vigorously endorse and promote voluntary prepayment medical care plans* as the most satisfactory method of financing the cost of medical care and to support the program initiated by the Michigan State Medical Society in the form of Blue Shield and Blue Cross Plans;

"5. Acquaint the public regarding the dangers of using federal tax mechanisms as a means of financing the cost of medical care for all *regardless of need*;

"6. Be it further resolved, that the Michigan State Medical Society shall actively support all groups having similar aims for the preservation of freedom of citizens *as opposed to centralized governmental controls*;

"7. We strongly believe in and vigorously support *individual initiative, individual responsibility and personal freedom* for all Americans;

"8. *We call upon each and every individual member* to implement the above and to encourage active participation in formulating our Country's future;

"9. And be it further resolved, that the Michigan State Medical Society will *actively and aggressively oppose HR 4222 (the King-Anderson Bill)* and all similar legislation which would in fact socialize the practice of medicine in the United States. Mr. Speaker, Robert L. Novy, M.D., Chairman, *moves* adoption of this report."

The motion was seconded by Claude L. Weston, M.D.

The Speaker called for discussion on the motion.

It was *moved* by Jacob F. Wenzel, M.D., and seconded by Alexander Blain III, M.D., that (2) above be amended to strike "As a last resort the Federal Government" and substitute therefore "and never the Federal Government." After discussion the House of Delegates voted and the motion was *defeated*. It was *moved* by Sidney Adler, M.D., and seconded by James D. Fryfogle, M.D., that (4) above be amended to strike "in the form of Blue Shield and Blue Cross plans." After discussion the House of Delegates voted and the motion *carried*. Paragraph 4 above was thereby amended to read: "Vigorously endorse and promote voluntary prepayment medical care plans as the most satisfactory method of financing the cost of medical care and to support the program initiated by the Michigan State Medical Society."

The Speaker then put the motion to adopt the report of the work shop on "Establishment of Position and Policy of Michigan Medicine," as amended.

The motion *carried* and the report, as amended, was adopted.

The Committee to establish position and policy submitted the following report:

"We highly commend and ask the support of the program proposed by Dr. Otto K. Engelke and presented to this House of Delegates and ask that it be actively implemented by the Michigan State Medical Society, its constituent county medical societies *as well as each individual physician in the State of*

(Continued on Page 652)

Statement of Principles For Lawyers and Physicians

(The following statement was developed by a special conference committee of the Michigan State Medical Society and the State Bar of Michigan in 1957, and was approved by both organizations. There have been many recent requests that the statement be reprinted.)

Preamble

In recognition of the public service obligations common to the medical and legal professions, and in the belief that such action will promote a closer cooperation and assist in maintaining a harmonious and compatible relationship between the two professions, thus serving the public interest, the Michigan State Medical Society and the State Bar of Michigan do hereby adopt the following Statement of Principles governing physicians and lawyers.

Medical Reports Requested by Attorneys

1. Where a report is requested by the patient's attorney, upon authorization from the patient, the physician should furnish to the attorney such report with reasonable promptness.
2. The contents of such report should be such as to permit the attorney to protect the interests of the patient fully and properly and compatibly with the attorney-client relationship.
3. When requesting such report, the attorney should clearly specify the information desired, and make known to the physician whether or not it is to embody opinions regarding diagnosis, prognosis and disability evaluation.
4. The attorney should recognize that it is not always possible for the physician to prepare a medical report on short notice. Where the physician may indicate that he deems it necessary or advisable before submitting such report to have the opportunity of seeing and examining the patient, the attorney should co-operate with the physician by arranging for his client to be seen by the physician.
5. When a medical report is requested by an attorney, he should not take the time of the physician for a conference unless:
 (a) It appears to the attorney that a conference is necessary for a proper report or
 (b) The physician requests such a conference before furnishing his report.
6. After the physician has furnished a report, if either the physician or the attorney feels it necessary or desirable to hold a conference with reference to the contents of the report, the attorney should be cognizant of the demands of time made upon the physician, and should co-operate to arrange such conference at a time and place indicated by the physician to be most convenient and suitable.

Co-operation Between Physician and Attorney In Cases Expected to be Tried and Where Attorney Proposes to Present Physician as a Witness

1. It is the duty of the attorney to furnish to the physician reasonable advance notice that the case is approaching trial, and that the physician is expected to be called as a witness in the trial of the case.



2. It is the duty of the attorney to make inquiry and ascertain from the physician as to any hospital records in appropriate cases, or other records not under the direct control or possession of the physician, including x-rays or reports the physician desires to have available at the time of his being a witness in the trial of the case, and to make the necessary arrangements so that such reports are thus available for the use of the physician at such time.

3. It is the duty of the attorney to request and remind the physician to bring with him at the time he appears as a witness his own office records with reference to his patient.

4. It is the duty of the attorney, after the physician requests the opportunity of seeing and examining the patient before trial, to arrange for the patient to be seen by the physician.

5. It is the duty of the physician at this time to review his own office records and any other records pertaining to his patient so as to cooperate with the attorney in the preparation of the trial of the case.

6. While the physician heretofore may have furnished a medical report to the attorney, the physician should recognize that such prior report likely was furnished for the principal purpose of permitting the attorney properly to plead his client's medical claims in the case. The physician should further recognize that at this time, for the attorney to protect fully the interest of his client, it may be necessary or advisable for the attorney to request a supplemental and amplified report in the preparation for the trial of the case, and it is the duty of the physician to cooperate with the attorney where authorized by the patient to furnish such supplemental and amplified medical report.

7. In some cases, it should be recognized by both the attorney and the physician that it is necessary or most desirable that a conference or conferences be had between the attorney and the physician in advance of the physician appearing as a witness in the trial of the case, whereby the physician is afforded an opportunity of discussing with the attorney the medical aspects of the case from the physician's viewpoint, particularly any technical medical matters pertaining thereto. An opportunity is thus afforded to the attorney of discussing with the physician the legal rules and the position occupied by the physician as a witness in the trial of the case, resulting in mutual cooperation for the best interest of the patient of the physician and the client of the attorney in the presentment of the case in court. Where, however, the physician and attorney mutually agree that such a conference is unnecessary, it should be avoided in the interest of saving the time of both the physician and the attorney. Where such conference or conferences are deemed necessary or advisable, the attorney should recognize a duty to arrange for the time and place for such conference or conferences as most convenient and suitable to the physician.

8. It is the duty of the attorney, in accordance with the ethics of his profession, that under no circumstances should he seek or attempt, in any manner, to persuade the physician to distort or color his testimony.

9. The physician should recognize the moral, as well as the legal, obligation of appearing in court as a witness on behalf of his patient, and should understand that medical testimony is frequently indispensable to prove or disprove medical claims presented in a case.

The Physician as a Witness in the Trial of the Case

1. It is required that parties, attorneys and witnesses, including physicians who are called to testify, recognize that the administration of justice by the courts and the trial of cases by the judges thereof cannot depend upon the convenience of such persons.

2. The attorney owes a duty to the physician who is to be a witness in the trial of the case to notify him as far in advance as possible as to when he is to be needed to testify, and to keep him informed and advised as to any changes with respect to the time of his appearance in court as the trial develops.

3. The attorney should notify the physician promptly of any settlement or other development during the trial of the case, the result of which is to eliminate the calling of the physician as a witness in the trial, so that the physician, who likely has set aside the time in which he is expected to be in court as a witness, may have the opportunity of making other commitments for this time.

4. The attorney should have available for the physician when he appears as a witness, all hospital and any other records which the attorney and physician have theretofore agreed shall be at the place of trial for the physician's use.

5. The physician should attend court at the time appointed. The attorney should appreciate, however, that a physician has continuing and often unpredictable responsibilities to his patients. Insofar as the attorney is able, he should make arrangements to permit the physician to testify with a minimum of inconvenience and delay to him.

6. The physician while testifying should answer questions as concisely and objectively as possible, with a terminology, when permissible, which will be most understandable to a jury of laymen.

7. If the physician is asked a question to which he does not know the answer, he should so state and make no attempt to speculate or guess or theorize or give answers not responsive to the question propounded, and the physician should not volunteer testimony.

8. In the giving of testimony, the physician, under no circumstances, should permit any bias, prejudice or favoritism or personal interest to influence or affect his testimony.

9. When questioning the physician-witness, an attorney should at all times refrain from unwarrantedly browbeating or badgering the physician. A physician testifying as a witness should know that if and when he feels that an attorney is improperly or unfairly conducting an examination of him as a witness, the physician may address the court and inquire if he is required to submit to such treatment.

10. The attorney owes a duty to the physician-witness to prepare and propound all questions to the witness in such form and manner as will permit a clear understanding and a forthright answer from the physician-witness.

11. An attorney who calls a physician to testify as an expert witness should, in advance of the physician's appearance in court, advise the physician of his intention to qualify and question him as an expert witness, and where it is proposed to use a hypothetical question, should in advance of the trial converse with the physician and explain to him the use of such hypothetical question so that at the time the physician in his capacity as an expert witness is propounded such question, he will have a reasonable understanding of the use of the hypothetical question and the limitations with reference to his answer to such form of question.

Compensation for Services of Physicians

1. It is the duty of the attorney, where necessary, to explain to his client the physician's bill for services and the itemization thereof. In cases where the physician aided in preparing the case but did not have the opportunity to testify or failed to testify because of a settlement prior to his being called as a witness, it is the responsibility of the attorney to advise his client of the physician's assistance and services in the case, and thus to cooperate with the physician for the purpose of seeing that such physician receives a reasonable fee for such services.

2. A physician who, at the request of an attorney, furnishes a medical report authorized by the patient, should receive a nominal fee for this service, and it is the duty of the attorney to cooperate with the physician to see that he receives such fee. If such medical report requires extraordinary services in its preparation either as to time and contents, or the case is of such a nature that the medical aspects thereof require the physician to have a conference or conferences with the attorney, or to furnish subsequent supplemental and/or amplified medical reports, the physician is entitled to a reasonable compensation for such professional services rendered, and it is the duty of the attorney to cooperate to see that such physician receives reasonable compensation in rendering such professional services. Where, after an original medical report, the physician is requested to perform further services in assisting in the preparation of the case for trial by furnishing supplemental or amplified reports and conferring with the attorney or rendering other services, it is recommended that when feasible, an agreed fee for such services be determined in advance after consultation with the attorney.

3. Where it appears that the patient is indigent or unable to make payment, the right to compensation for services in assisting the attorney in the preparation of the case for trial may be waived by the physician, or where it appears that the financial status of the patient is such that ordinary reasonable compensation to the physician for his services will work a hardship, the physician may take this into consideration in determining his fee for services in assisting the attorney in the preparation of the case for trial.

4. Where a physician testifies as a witness, under no circumstances should the physician's charge for his time as a witness, or his fee, if qualified and testifying as an expert witness, be contingent or determined by the amount of the recovery of the patient in the litigation, or the success or lack of success of the patient's case.

5. Compensation for the services of a physician in connection with assisting in the preparation of the case or for his appearance as a witness in court should be on a reasonable basis and based on the time and nature of the services performed.

6. It is the duty of the attorney to cooperate fully with the physician by assisting the physician to obtain payment for services properly rendered by the physician to his patient in the physician-patient relationship. It is the further duty of the attorney to cooperate with the physician to obtain payment from the patient for services rendered by the physician to the attorney in the preparation and/or trial of the patient's case.

Inter-Professional Courtesy and Understanding

1. For the medical and legal professions to perform the full duties owed to society by each, it is required that the members of each profession extend toward the other full courtesies and amenities and engage in a mutual understanding of the problems of each other.

2. It is required that the attorney understand the vast demands made upon the time of the members of the medical profession, and at all times to avoid unnecessarily claiming the time of any physician either in the attorney's preparation of the case for trial, or while engaged in the trial of the case.

3. It likewise is required that the physician understand that in many instances the legal rights to the patients, in litigation having medical aspects, may be properly protected only by the attorney seeking and obtaining the time and services of the physician in the preparation and trial of the case.

4. Courtesy requires, where necessary, that the attorney assist and enlighten the physician with respect to his position as a witness in the trial of the case, his role as a witness, and the rules to be observed in connection with the matter of giving testimony in court.

5. Courtesy requires of the physician that he aid the attorney so that the attorney may be enlightened on the highly specialized medical aspects of the case, and may be assisted in properly presenting in the trial of the case the medical phases involved through sufficient understanding with the physician to conduct an intelligent examination of the physician witness.

6. Courtesy requires that the attorney cooperate with the physician to minimize as far as practicable the time required for the physician to remain in court.

7. If an attorney plans to have a subpoena served upon a physician, wherever practicable, the physician should be notified in advance and service made under arrangements convenient and acceptable to the physician.

8. Courtesy requires that wherever practicable, the attorney and physician should consult in advance with reference to the fee of the physician to be charged for his time spent in attendance in court as a witness.

9. Courtesy requires that where, by requirement of statute, the amount of an expert's fee may be set only by the court, the physician be notified thereof in advance, with the further assistance of the attorney that he will petition the court, at the proper time, for an order setting a proper and reasonable fee for the physician's services as an expert witness.

Excess and Undesired Narcotics

Excess and undesired narcotic drugs may be shipped to the *District Supervisor, Bureau of Narcotics, 608 Federal Building, Detroit 26, Michigan,* by express—*charges prepaid,* for disposition. *No remuneration will be made for these surrendered drugs.*

1. Form 142 titled "Registrant's Inventory of Drugs Surrendered" will be furnished to registrants, upon request.

2. Form 142 must be prepared in quadruplicate, listing all items of narcotics being surrendered, and each form signed by the registrant or authorized agent surrendering the narcotics.

3. All the Form 142 (Original and three copies) should then be mailed to the District Supervisor, Bureau of Narcotics, 608 Federal Building, Detroit 26, Michigan, with a brief letter advising the date of shipment of the drugs, and a description of the size of the carton.

4. Ship the narcotic drugs by *Express-Charges Prepaid* to the District Supervisor, Bureau of Narcotics, 608 Federal Building, Detroit 26, Michigan.

5. Upon receipt of the drugs, a Form 142 will be receipted, and mailed to the registrant surrendering the drugs. This Form 142 should be retained in the registrant's files for a period of two years, as required by law.

Special Session of the House of Delegates

(Continued from Page 648)

Michigan. Mr. Speaker, Robert L. Novy, M.D., Chairman, *moves* adoption of this report."

The motion was seconded by J. Leonidas Leach, M.D., and unanimously *carried.*

A. Carl Stander, M.D., *moved:* "Be it resolved, that the House of Delegates of the Michigan State Medical Society express its grateful thanks to the Michigan State University and the Kellogg Center and their personnel for the fine cooperation and excellent facilities for this special session." The motion was seconded by R. Wallace Teed, M.D., and unanimously *carried.*

Louis J. Bailey, M.D., *moved:* "Be it resolved, that the House of Delegates of the Michigan State Medical Society hereby expresses its commendation to the Speaker of the House, the Vice-Speaker, Mr. Hugh W. Brenneman and his staff for the excellence of their work in connection with this special session." The motion was seconded by several and unanimously *carried.*

It was then *moved* by several, seconded by several and *carried* that the special session of the House of Delegates adjourn, the time then being 4:29 p.m.

J. J. LIGHTBODY, M.D.
Speaker of the House of Delegates
Michigan State Medical Society

AMA Auxiliary Will Fete Mrs. Mackersie

The 38th annual convention of the Woman's Auxiliary to the AMA, June 26-29, will honor the president, Mrs. William G. Mackersie, of Detroit, at the annual tea in the United Nations Building.

More than 3,000 physicians' wives will attend the Auxiliary meeting in New York City. Besides regular business sessions, presentations will be made in the fields of civil defense, safety, health careers, mental health and community service. A guest speaker will be Dr. E. Vincent Askey, AMA president.

Health Council Meeting Lists M.D. Speakers

Michigan State Medical Society members plus Auxiliary members are well represented on the program for the Michigan Health Council State Health Conference, to be held at Ballenger Field House, Flint Junior College, May 23-25.

Nineteen Society members are scheduled to speak during the three day meeting.

Mrs. William Mackersie, Detroit, president of the Auxiliary to the American Medical Association, will extend greetings to Conference participants at the Annual Banquet, May 24.

Earle Ingham Carr, M.D., Lansing, President, Michigan Foundation for Medical and Health Education, also will appear on the banquet program.

Charles J. Tupper, M.D., assistant dean, University of Michigan Medical School, is chairman of a panel on health careers, May 22. Sidney E. Chapin, M.D., Dearborn, president of the Michigan Health Council, and Harry A. Towsley, M.D., Ann Arbor, will take part in opening day ceremonies. Doctor Towsley is General Chairman of the Conference.

Mrs. Paul Ivkovich, Reed City, president of the Woman's Auxiliary to the Michigan State Medical Society, will chair a panel on the MSMS President's Program, May 24. Also appearing on the program that day are Evelyn Golden, M.D., Flint; Leslie V. Burkett, M.D., Flint; Vlado A. Getting, M.D., Ann Arbor, and Mrs. Vernon V. Bass, Saginaw, Auxiliary Health Careers Recruitment Chairman.

The second day of the Conference is also devoted to aging. Doctors appearing on the program of the Joint Council to Improve the Health Care of the Aged are A. Hazen Price, M.D., Detroit; Harry B. Zemmer, M.D., Lapeer, president emeritis, Michigan Health Council; C. Howard Ross, M.D., Ann Arbor; Otto K. Engleke, M.D., past-president of MHC; Albert H. Hirschfeld, M.D., Detroit; and Frederick C. Swartz, M.D., Lansing.

The Thursday program features Kenneth H. Johnson, M.D., Lansing, president of MSMS; Goldie Corneilson, M.D., Lansing; John Rogers, M.D., Bellair; S. D. Steiner, M.D., Detroit; J. K. Altland, M.D., Lansing, and Earle I. Irvin, M.D., Dearborn.





William M. LeFevre, M.D., Muskegon, first president of MAP, presides at the President's Dinner Dance.



Charles R. Sligh, Jr. *(left)*, executive vice president of the National Association of Manufacturers and keynote speaker at the Congress of the Professions, confers with Lester P. Dodd, Detroit, MSMS legal counsel, who was general chairman of the Congress.

MAP Congress



(At right) Thomas A. Francis, Jr., M.D., chairman, Department of Epidemiology, University of Michigan, discussed the "Great Accomplishments in Medicine."



MSMS members meet with state and national representatives from each member profession of MAP to explore the potential of an American Association of the Professions; its needs, services, and its relationship to existing state and national professional associations at the MAP Congress. *(Left to right)*: Drs. J. C. Day, John S. Jewell, Scipio G. Murphy, Richard C. Deming, Alexander Blain, III, Everett L. Phelps and J. R. Rupp. All are from Detroit with the exception of Dr. Phelps, who is from Hastings.

"Independence of Thought; Unity of Action," MAP Theme

The "great thoughts," "great accomplishments" and "great challenges" of the professions were the main subjects of addresses given by nationally-known speakers highlighting the 3-day program of the 2nd Annual Congress of the Professions in Detroit, recently.

Of special interest were the assemblies devoted to the great deeds of the professions.

* * *

SPEAKING FOR MEDICINE, Dr. Thomas E. Francis, Jr., M.D., professor and chairman of the Department of Epidemiology, Virus Laboratory, School of Public Health, University of Michigan, outlined the "greatest designed experiment in medical history," the polio field trial of 1954.

Philip Jay, D.D.S., professor of the School of Dentistry, U. of M., gave the inside story of fluoridation, its world-wide acceptance as a safe and practical health measure and the active opposition afforded it.

W. W. Armistead, dean of the College of Veterinary Medicine, Michigan State University, told of the great accomplishments in veterinary medicine and the part they had contributed to the advancement in human medicine.

Stephen Wilson, Ph.D., dean of Pharmacy, Wayne University, emphasized how greater specialization and diversification in the profession of pharmacy has led to its phenomenal growth.

And speaking for engineering, Dr. Harold S. Black, consultant in Systems Research of the Bell Telephone company, told of modern day miracles accomplished in the field of satellite communications. Each profession gained a greater insight and respect for the other as these accomplishments were discussed.

* * *

IN ADDRESSES STRESSING the Congress theme, "Independece of Thought; Unity of Action," other top name speakers appearing before the Congress were unanimous in their praise of MAP's leadership in mobilizing the potential strength of united professionalism as a powerful force for common good.

The keynote speaker was Charles R. Sligh, Jr., New York, executive vice-president, National Association of Manufacturers. He said that all citizens and especially the wisest and most capable must always be ready to give their best services to the community, town, city, state or nation. World tensions are great but will not prevail if our citizens are ready and willing with their counsel and effects if necessary.

The first day was devoted to six committee luncheons and hearings: Business services and techniques, Education, Legislation, Publication, Public Relations and Citizens Committee. Hearings were also held on the different areas.

In the evening was the President's Dinner Dance, with Wm. M. LeFevre, M.D., presiding. Lester P. Dodd, Detroit, was toastmaster.

During the "Great Thoughts" session three speakers gave their offerings from their professional and personal experiences: Paul A. Miller, Ph.D., provost, Michigan State University; William E. Stirton, Ph.D., vice-president, University of Michigan and director of the Dearborn Center; and C. S. Steiner, S.J., chancellor, University of Detroit. They spoke about what individuals, the professions and the people may look forward to, how to guide the future and obtain the most good for all.

The speaker at the second evening banquet was the Honorable John S. Dethmers, LL.B., Chief Justice of the Supreme Court of Michigan who spoke on "The Role of the Courts."

* * *

FIVE MSMS MEMBERS now serve on MAP's Board. They include: John W. Rice, M.D., Jackson, elected by the membership at the annual business meeting and Gilbert B. Saltonstall, M.D., Charlevoix, one of the founders of MAP who was reappointed by MSMS as its representative. Both will serve for a two-year term. William M. LeFevre, M.D., Muskegon, also a founder of MAP and its first president, will complete his term as president but will remain on the Board for another year as will John G. Manning, M.D., Saginaw and Luther R. Leader, M.D., Detroit.

Officers for 1961 were elected by the Board at its March meeting: John Nolen, D.D.S., Lansing, was elected president, Nathan B. Saulter, P.E., Detroit, vice president, Hollis Clark, Jr., DVM, Holland, treasurer and Elmer Mansm, A.I.A., Lansing, was-re-elected secretary.

A Town Hall type meeting to consider the needs for an American Association of the Professions was held during the closing afternoon of the Congress. National leaders of the member professions participated in the discussions. Ernest B. Howard, M.D., assistant executive vice president of AMA, spoke for the medical profession. Further deliberations by national professional leaders on AAP will be held at a meeting scheduled for mid-summer.

Rename John N. Lord President Of Michigan Blue Cross

John N. Lord continues as president of Michigan Blue Cross re-elected recently for his fifth consecutive term. Mr. Lord is president of Lee & Cady and vice president of Grace Hospital in Detroit.

Elected vice president was John W. Paynter, who is vice president and treasurer of the J. L. Hudson Company. Ralph E. Phelps was re-elected treasurer, Wm. S. McNary was re-elected secretary and Hazel Kennedy re-elected assistant secretary. Mr. Phelps is assistant secretary of the S. S. Kresge Company.

O. O. Beck, M.D., of Birmingham, and James W. Logie, M.D., of Grand Rapids, were re-elected as medical representatives on the board of trustees.

Detroit Clinic Moves

The Social Hygiene Clinic of the Detroit Health Department has moved from its present quarters in Receiving Hospital to 8811 John C. Lodge, in building 7, Herman Kiefer Hospital. The telephone number is TRinity 2-7441, according to Benjamin Schwimmer, M.D., clinic director.

National Occupational Medicine Conference Held in Detroit

Two hundred members of the American Academy of Occupational Medicine met at the Detroit Statler Hotel February 8 for their annual three-day meeting. Chairman was Arthur J. Vorwald, M.D., chairman of the Industrial Medicine and Hygiene Department at Wayne State University College of Medicine.

On the scientific program committee were Duane Block, M.D., medical director, Rouge Division, Ford Motor Company; Edwin DeJongh, M.D., Pontiac Division, General Motors; William Jend, Jr., M.D., medical director, Michigan Bell Telephone Company; Seward Miller, M.D., professor of occupational medicine, University of Michigan; S. Dan Steiner, M.D., medical director, General Motors Corporation.

Editorial Comment:

The Lines Are Drawn Again

Despite the fact that Congress enacted a broad new program for health care of the needy and near-needy aged last year, President Kennedy and the Democratic leaders of Congress will push for a compulsory program tied to Social Security during the 1961 session.

Proponents of Forand-type legislation have tried to belittle the Kerr-Mills Bill as "inadequate" and a "stop-gap measure." Actually, the Kerr-Mills Bill will require hundreds of millions of dollars and will provide care for *all* persons over 65 who *need* help.

Before Georgia and the other states will hardly have had an opportunity to participate in this new program, the Democratic administration will be pushing for a national compulsory program to include all persons over 65 whether they need it or not. Decisions as to eligibility, benefits, fees, and all other matters will be made in Washington rather than at the state and local level as under the Kerr-Mills Bill.

All of these factors were made abundantly clear during the recent 14th Clinical Meeting of the American Medical Association in Washington, D. C. It was most appropriate that the meeting was held in Washington, for many of the statements by the officers of the Association and by the House of Delegates seemed directed as much to the new administration as to the physicians.

These statements reaffirmed medicine's opposition to social security medicine and urged all physicians to support state officials and provide leadership in implementing the Kerr-Mills Bill. The statements were clear and left no doubt as to where medicine stands.

As the 1961 session of Congress progresses, we wish to urge every physician in Georgia to keep himself, the members of his community, and his Congressman informed on this vital issue. The influence of one man may make the difference between the free practice of medicine and high standards on the one hand, and national compulsory health insurance and uniformly lower standards on the other.—*J.M.A. Georgia.*

MICHIGAN MEDICAL MEETINGS AND CLINIC DAYS

May	23-25	Michigan Health Council State Conference	Ballenger Field House, Flint
June	4	Dedication of New MSMS Headquarters	Community College, Flint
June	16-17	Upper Peninsula Medical Society	East Lansing
June	19-21	University of Michigan Conference on Aging	Menominee
July	27-28	Coller-Penberthy Clinic	Ann Arbor
Sept.	27-28	Michigan State Medical Assistants Society	Park Place Hotel, Traverse City
Sept.	27-28	Woman's Auxiliary to MSMS	Pantland Hotel, Grand Rapids
Sept.	27-29	MSMS Annual Session	Pantland Hotel, Grand Rapids

"Teamwork," Theme For AMA Meeting

The American Medical Association's 110th annual meeting will attract an estimated 50,000 persons, including 25,000 physicians, into New York City, June 25-30. The convention will develop a theme of "Teamwork in Medicine."

The AMA meeting will open formally on Sunday, June 25, with a special preview luncheon and showing in the Coliseum for AMA officers and committee chairmen, members of the Board of Trustees, representatives of the Pharmaceutical Manufacturers' Association and invited guests.

Leonard W. Larson, M.D., 63-year-old pathologist from Bismarck, N. D., will be inaugurated as president of the AMA at 8:30 p.m., Tuesday, June 27 in the Waldorf-Astoria ballroom. Dr. Larson succeeds E. Vincent Askey, M.D., Los Angeles.

The AMA House of Delegates will meet at the Statler-Hilton, the headquarters hotel, at 10 a.m., Monday, June 26. The first order of business will be to select the recipient of the AMA Distinguished Service Award given annually to the physician who has made an outstanding contribution to medicine.

Matters to be considered by the House will, in all probability, include:

—A supplemental report relating to closer cooperation between the American Medical Association, the American Hospital Association, the National Association of Blue Shield Plans, and the Blue Cross Association in promoting "maximum development of the voluntary non-profit prepayment concept to provide health care for the American people."

—A report by the AMA Judicial Council, the "supreme court" of medicine, which will cover the controversial relationship between doctors of medicine and doctors of osteopathy.

—Group disability insurance for all members of the American Medical Association.

—A status report by the AMA Commission on the Cost of Medical Care, which is presently studying all facets of the broad medical care cost problem.

—A final report by a committee which studied all mechanisms for disciplining members of the medical profession.

—Washington legislation, especially various aspects of President Kennedy's program for health care of the aged through social security.



MICHIGAN DEPARTMENT OF HEALTH
ALBERT E. HEUSTIS M.D., State Health Commissioner

Operation Seat Belt

The Michigan Department of Health has been increasingly concerned about the fact that we have in this country a means of saving many lives and preventing many more severe injuries but do not make much use of it. We refer, of course, to seat belts. Surveys indicate that only about two per cent of the cars in this country are equipped with seat belts. Worse, only about one out of three of the people who have them, actually use them.

While seat belts are not quite in the same category as vaccines, there is a similarity in that both are capable of preventing disability and death. If only about two per cent of our people had purchased polio vaccine—and if two out of three of them carried it around in a vial—we would consider it a national disgrace. Yet this is precisely what is occurring with regard to seat belts.

We decided to make a tentative start toward improving this situation. We had from time to time sent out press releases and radio spot announcements promoting seat belts. We therefore decided to go ahead on our own and provide seat belts to our employees who were assigned a state car. These belts would be paid for out of our operating funds. We received requests for 68 belts to be installed in 38 cars. The only stipulation was that the belts must be requested in writing and that each person must agree to use them.

Having done this, we decided that we should see what could be done to make seat belts available to our own employees, inexpensively and at little inconvenience. It has always been a basic part of our philosophy that a public health measure must be not only effective but readily available and relatively inexpensive if it is to be widely accepted and used. Obviously, one of the problems with regard to seat belts is cost as well as inconvenience. We therefore checked with various local dealers until we got what we considered to be the best price possible—$6.72 per belt including tax and installation. These belts exceeded the recommendations of the Society of Automotive Engineers. Arrangements were then worked out so that employees could, if they wished, have their cars driven to the garage and the belts installed while they were at work. Thus, while the cost was still more than nominal, it was most reasonable, and the installation of the belts could be done at no inconvenience.

Once these things had been established, we began an educational campaign within the department, using our weekly news sheet as a medium of communication. A special fact-sheet on seat belts was prepared and distributed with the news sheet. A motion picture, *Safety Through Seat Belts,* which is in our film library, was shown to all those who wished to see it. This was done on company time and took about twenty minutes. Finally, samples of the various colors of belts were displayed in our lobby along with a register in which people could sign up for the number and color of belts desired.

At the end of the program, 243 seat belts were ordered by 102 people. Including our state cars then, 136 cars have been equipped with seat belts as a direct result of our program. As such, the program cannot be considered an overwhelming success. But it does represent about 25 per cent of our total employees—well above the 2 per cent average in the nation.

Another by-product of this seat belt program has been the recent announcement by Governor Swainson that seat belts will be installed in all state cars upon request of the persons to whom the cars are assigned. By the end of the year, according to Governor Swainson, all state cars will be so equipped.

The seat belt program was organized to achieve two goals. One, to demonstrate our own conviction of the importance of these belts so that we could more effectively urge that all state cars be equipped with them. This has already paid off. Second, we hoped to determine whether or not an extensive public education program would be of any real value. The answer to this is not so obvious. It is clear, however, that next year, when all automobile manufacturers plan to produce cars with seat belt fittings as standard equipment, public education on a continuing basis will be of some value.

Perhaps more significant is the realization that any business or industry can expect a considerable interest in, and acceptance of, seat belts if a program is conducted which will make them available at a reasonable cost and with little inconvenience. It is toward the promotion of such efforts that we feel we can be most effective at the moment.

We shall be glad to share with any local medical society any material used in our campaign.

Winslow Homer "THE HERRING NET" *Art Institute of Chicago.*



STRAIN

Strain is a necessary component of man's efforts to move his external environment, but all too often brings on extreme pain and trauma when hard stools are moved after repair of rectal disorders. Metamucil adds soft, bland bulk to the bowel contents to stimulate normal peristalsis and also hold water within stools to keep them soft and easy to pass. Thus Metamucil, with an adequate water intake, is of great help in minimizing painful trauma to postsurgical rectal tissue. Metamucil promotes regularity through "smoothage" in all types of constipation.

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Available as regular Metamucil or as the new lemon-flavored Instant Mix Metamucil

SEARLE

HEART BEATS

(This material is provided by the Michigan Heart Association)

New MHA Officers

John D. Littig, M.D., Kalamazoo, is the new president of the Michigan Heart Association, elected at the annual meeting of members on "Michigan Heart Day" at the Statler-Hilton Hotel. Muir Clapper, M.D., Detroit, became president-elect, Lawrence Dooge, Grand Rapids, first vice-president and Mrs. James McEvoy, Detroit, second vice-president. Sidney E. Chapin, M.D., Dearborn, and W. C. Folley, Sc.D., Detroit, were re-elected as secretary and treasurer, respectively. New trustees are: Douglas Giles, Birmingham, Albert Heustis, M.D., Lansing, Mrs. Norris A. Host, Birmingham, Bernath P. Sherwood, Jr., Spring Lake, Robert Stow, M.D., Lansing, and Randall M. Whaley, Ph.D., Detroit.



JOHN D. LITTIG, M.D.

New Staff Member

Seymour Brieloff is the new director of Michigan Heart Association's Eastern Regional Office in Flint. Mr. Brieloff was formerly the director of operations for the Community Workshop of the Jewish Vocational Service in Detroit, where he had previously served as career counselor. Born in New York city, he obtained his Master of Education degree at the University of Miami, and brings 10 years of experience in the field of rehabilitation to the Heart Association.

Wet Clinics' Purpose and Procedures

The primary purpose of the Congenital and Rheumatic Heart Disease Wet Clinic is to teach diagnostic and therapeutic methods in congenital and rheumatic heart disease. The experience of the conducting physician, internist, pediatrician or cardiovascular surgeon, is drawn upon to aid the attending physicians in examining, evaluating and managing cardiac patients, and to better judge which patients may profit from angiocardiography and cardiac catheterization and other of the newer diagnostic tools in determining the feasibility of cardiac surgery.

A single wet clinic can probably best manage six to eight patients, with two to six participating doctors. Patients are selected from a wide range of cardiac disorders. Written histories and records of patients should be available, as well as x-rays, ECG's and laboratory studies for the attending physicians' information. Clinics are followed by a discussion period on the general problems involved.

The Michigan Heart Association will underwrite the payment of the honorarium and expenses of your consultant and therefore no charge will be made to the patients by the consultant.

For further information write: John G. Bielawski, M.D., Medical Director, Michigan Heart Association, 3919 John R, Detroit 1, Michigan.

Heart Disease Control

An institute on Heart Disease Control will be conducted by the University of Michigan School of Public Health from June 26 through July 1 in Ann Arbor. The Michigan Heart Association is one of the collaborating agencies in the program which includes lectures, seminars, discussion and demonstration from the aspects of Epidemiology, Prevention, Early Detection, Rehabilitation, Nutrition and Nursing related to Heart Disease.

Registration application must be sent not later than June 1 to: Director, Continued Education, School of Public Health, The University of Michigan, Ann Arbor, Michigan.

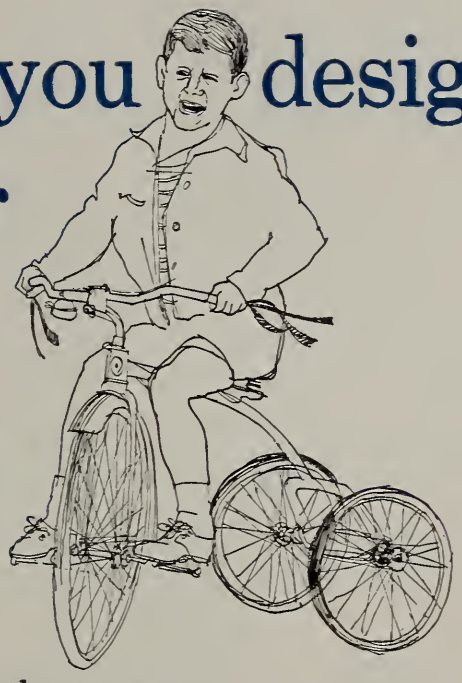
Association's Research Program, 1961-1962

The Michigan Heart Association Research Committee recommendations for 1961-62 approved by the Board of Trustees, have been allocated as follows:

1.	Dean's Fund	$ 60,000.00
2.	Medical Student Research Fellowships (25 at $600.00)	15,000.00
3.	Contingency Fund	15,000.00
4.	Grants-in-Aid	261,639.05
	TOTAL	$351,639.05

(Continued on Page 662)

how would you design a tranquilizer specifically for children?



wouldn't you want it to be:	see how closely these ATARAX advantages meet your standards:
efficacious	"... Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...."[1]
remarkably well tolerated	"The investigators were impressed with the lack of toxicity and minimal side effects which were observed even after long-term use."[2]
palatable	Delicious ATARAX syrup pleases even the balkiest patient.

Nor is that all ATARAX has to offer. In the allergic child, ATARAX offers added antihistaminic action to help control asthma and urticaria.[3] In fact, though outstandingly useful in children,[1-4] ATARAX equally well meets the needs of the elderly, and of the tense working adult (it calms, seldom impairing mental acuity). Why not extend its benefits to *all* your tense and anxious patients?

Dosage: For children: under 6 years, 50 mg. daily; over 6 years, 50-100 mg. daily; in divided doses. For adults: 25 mg. t.i.d. to 100 mg. q.i.d. *Supplied:* Tablets 10 mg. and 25 mg., in bottles of 100 and 500. Tablets 100 mg., in bottles of 100. Syrup, 2 mg. per cc., in pint bottles. Also available: Parenteral Solution. Prescription only.

References: 1. Freedman, A. M.: Pediat. Clin. North America *5*:573 (Aug.) 1958. 2. Nathan, L. A., and Andelman, M. B.: Illinois M. J. *112*:171 (Oct.) 1957. 3. Santos, I. M. H., and Unger, L.: Ann. Allergy *18*:179 (Feb.) 1960. 4. Litchfield. H. R.: New York J. Med. *60*:518 (Feb. 15) 1960.

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Science for the World's Well-Being®

VITERRA® Capsules—Tastitabs®
—Therapeutic Capsules for
vitamin-mineral supplementation

Association's Research Program

(Continued from Page 660)

Grants-in-Aid were awarded to ten Michigan Medical institutions for research under the direction of responsible investigators as follows:

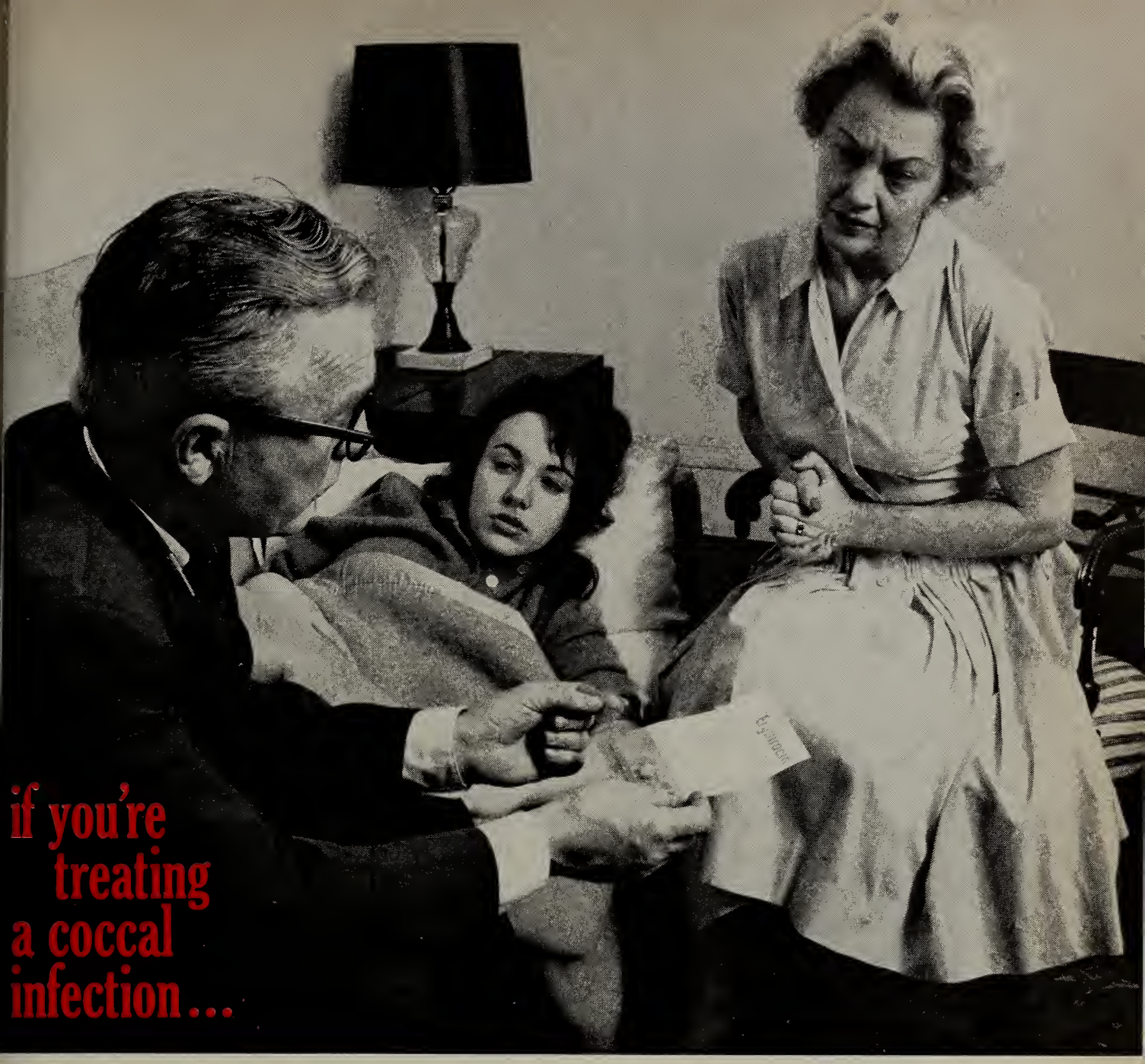
1. Marion I. Barnhart, Ph.D., *Wayne State University*
"Cellular Sites for Synthesis of Proteins Important in Blood Coagulation."
2. Bernard Bercu, M.D., *Wayne County General Hospital*
"Myocardial Blood Flow Using Radioactive Sodium."
3. Richard Bing, M.D., *Wayne State University*
"Myocardial Metabolism and Contractile Proteins of the Heart."
4. A. J. Boyle, M.D., *Wayne State University*
"Plasma Colloid Stability in Normal and Atherosclerotic Subjects."
5. Geo. O. Clifford, M.D., *Wayne State University*
"Mechanism of the Coagulation Abnormalities Induced by Hyperlipemia and Its Modification by Certain Agents."
6. Vernon N. Dodson, M.D., *University of Michigan*
"Anti-heart Antibodies."
7. F. D. Dodrill, M.D., *Harper Hospital* (Cariovascular Surgery)
"Synthetic Heart Valve."
8. F. E. Greifenstein, M.D., *Wayne State University*
"The Use of the Buffer Amines for Reversing Respiratory Acidosis During Anesthesia and Surgery."
9. Sibley Hoobler, M.D., *University of Michigan*
"Arteriosclerosis and Hypertension."
10. Thomas James, M.D., *Henry Ford Hospital*
"Morphologic Studies of the Human Heart with Clinical Correlation."
11. Prescott Jordan, Jr., M.D., *Wayne State University*
"Aortic Valvular Replacement."
12. Jon J. Kabara, Ph.D., *University of Detroit*
"Simultaneous Use of Tritium and Carbon-14 Metabolites to Study the Dynamics of Lipid Metabolism."
13. Conrad Lam, M.D., *Henry Ford Hospital* (Cardiovascular Surgery)
"Experimental Cardiovascular Surgery."
14. B. M. Lewis, M.D., *Wayne State University*
"Pulmonary Capillary Bed in Cardio-Respiratory Disease."
15. Perry Martineau, M.D., *Herman Kiefer Hospital*
"Blood Viscosity in Relation to Coronary Atherosclerosis."
16. John S. Meyer, M.D. *Wayne State University*
(A) "Clinical Evaluation of Combined Fibrinolysin and Anticoagulant Therapy in Cerebrovascular Disease."
(B) "1—Pathogenesis of Vasospasm in Hypertensive Encephalopathy. 2—Cerebral Metabolism and Blood Flow in Vascular Disease."
17. N. J. Mizeres, M.D., *Wayne State University*
"Neural Effect on the Coronary Blood Flow."
18. Joe Morris, M.D., *Wayne State University*
"A Comparison Study of Valvuloplasty Techniques Using the Pulse Duplicator and Post Mortem Hearts."
19. E. E. Muirhead, M.D., *Woman's Hospital*
"The Influence of Renal Cells Grown in Tissue Culture on Experimental Hypertension."
20. A. C. Nolke, M.D., *Children's Hospital*
"Blood Pressure Determination in Small Infants."
21. Jan Nyboer, M.D., *Harper Hospital*
"Evaluation of Ultra-Low Frequency Ballistocardiography and Electrical Impedance Plethysmography."
22. C. J. Parker, Jr., Ph.D., *Wayne State University*
"The Action of Anserine and Carnosine on the Mg-activated Myofibrilar Adenosine Triphosphatase Activity of Cardiac and Skeletal Muscle."
23. R. C. Reynolds, *University of Michigan*
"A Study of the Effect of pH and Ionization on the Actions of the Sympathominetic Amines on the Vascular System of the Cat and Rabbitt."
24. H. J. Robb, M.D., *Wayne State University*
"Study of Microscopic Vascular Dynamics in Various Forms of Shock and Study of Vascular Changes Which Occur with Administration of Drugs Which Change the Caliber of Vessel and Affect Their Blood Flow."
25. P. A. Rondell, Ph.D., *University of Michigan*
"Electrolyte Movements and Vascular Muscle Contraction."
26. J. N. Schaeffer, M.D., *Rehabilitation Institute*
"Objective and Subjective Physical Disability Evaluation in Hemiplegia."
27. W. H. Seegers, Ph.D., *Wayne State University*
"Blood Coagulation: Purification of Inhibitors and Mechanisms of Their Action."
28. J. C. Sisson, M.D., *University of Michigan*
"I^{131} Labeled Fat in Myocardial Infarct Patients."
29. Herbert Sloan, M.D., *University of Michigan*
"Transplantation of the Heart."
30. Aaron Stern, M.D., *University of Michigan*
"The Development of an Intracavitary Combination Electrocardiographic and Phonocatheter Permitting Heat Sterilization. The Building of a Preamplifier for Intracavitary Phonocardiography."
31. D. E. Szilagyi, M.D., *Henry Ford Hospital*
"An Investigation of the Use of Vascular Substitutes in the Replacement of Arterial Segments."
32. D. E. Vernall, Ph.D., *University of Michigan*
"The Teratogenic Effects of Trypan Blue on the Cardiovascular System of Mice."
33. J. M. Weller, M.D., *University of Michigan*
"Investigation of Abnormalities of Sodium and Potassium Metabolism in Hypertension."
34. P. Willis, III, M.D., *University of Michigan*
"Investigation of the Mechanism of Blood Coagulation with Special Reference to Problems of Thromboembolic and Arterial Occlusive Disease."
35. A. J. Zweifler, M.D., *University of Michigan*
"Effect of Heparin on Experimental Thrombosis in Dogs."
36. W. S. Wilson, M.D., *University of Michigan*
"1—Changing Intracardiac Conductivity and the EKG. 2—The Effect of Denervation of the Lung on Hypoxic Pulmonary Hypertension. 3—Changes in Sodium Excretion after Closure of Left to Right Shunts. 4—Preliminary Studies on the Denervated Heart."

AMA Sees Danger in Trampolines

Trampoline acrobatics performed by untrained amateurs can cause crippling and even fatal injuries, the American Medical Association said in a warning.

An editorial in the November 26 *AMA Journal* pointed out the dangers of increased popularity of trampoline tumbling among novices without proper supervision or instruction.

The most dangerous place on the trampoline is still the center of the mat, the *Journal* says.



you can't prescribe a more effective antibiotic than ERYTHROCIN®

Erythromycin, Abbott

How much "spectrum" do you need in treating an infection? Clearly, you want an antibiotic that will show the greatest activity against the offending organism, *and the least activity against non-pathogenic gastro-intestinal flora.*

Weigh these criteria—and make this comparison—when treating your next coccal infection. Erythrocin is a medium-spectrum antibiotic, notably effective against gram-positive organisms. In this it comes close to being a "specific" for coccal infections—*which means it is delivering a high degree of activity against the majority of common infection-producing bacteria.*

And against many of the troublesome "staph" strains—a group which shows increasing resistance to penicillin and certain other antibiotics—Erythrocin continues to provide bactericidal activity. Yet, as potent as Erythrocin is, *it rarely has a disturbing effect on normal gastro-intestinal flora.* Comes in easy-to-swallow Filmtabs®, 100 and 250 mg. Usual adult dose is 250 mg. every six hours. Children, in proportion to age and weight. Won't you try Erythrocin?

®Filmtab—Film-sealed tablets, Abbott.

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Pathology Comment

These items are provided by the Michigan Pathological Society

Contraindications for Blood Transfusions

"Thoughtless prescription of blood transfusion is playing Russian Roulette with bottles of blood instead of a revolver. While the odds are in the physician's favor that nothing will go wrong, the patient takes the risk." This statement by Crosby† succinctly summarizes blood transfusion hazards.

Each year 3,000 persons die from an estimated 3.5 million blood transfusions; transfusions rank with appendicitis and anesthesia as causes of death. A legal opinion on blood transfusions has pointed out that a physician would be liable for damages following and caused by a transfusion that was not indicated by the facts of the case.

Even if no negligence could be proved, an action for damages would lie if the plaintiff could prove that a transfusion was not indicated medically. Fortunately this situation rarely presents itself in court, but the proper indications for transfusion deserve most careful consideration at all times. It is not a decision to be made lightly, and a surgical operation per se is not sufficient reason.

We must remember that we are treating the patient, not his laboratory reports or our own anxiety. Transfusions are neither tonics nor placeboes; they are not substitutes for careful medical or surgical therapy. It is far better to treat a simple iron deficiency anemia by iron replacement than by transfusions. As a single unit of blood only provides the patient with 1 to 1.5 gm. of hemoglobin per 100 ml. of blood, the use of a single unit transfusion is rarely justified in view of the hazards involved.

Before ordering the next transfusion, please consider the following risks:

1. Hepatitis
2. Reaction from incompatible blood
3. Allergic reactions
4. Sensitization of the patient
5. Possible bacterial contamination

Except for exchange transfusions there are two indications for blood transfusion:

1. Improvement of circulatory system stability by replacement of blood volume where the patient's life is imperiled.

2. Prevention of acute hypoxia or shock by improving the oxygen-carrying capacity of the blood.

These are the facts to consider. The decision is yours.

†Crosby, W. H.: *Blood*, 13:1198, 1958.

Brief and to the Point

RECEIVES AWARD—Lynn A. Ferguson, M.D., Grand Rapids, recently received the third annual Aquinas College Award. The Rt. Rev. Msgr. Arthur F. Bukowski, Aquinas president, presented the bronze medallion at a special honors convocation at the school. It cited Dr. Ferguson's "pioneering achievement in the field of proctology and . . . his inestimable contribution to the civic and social welfare of Grand Rapids."

* * *

FETED BY COMMUNITY—Community leaders of Addison, in Southern Michigan, honored B. H. Growt, M.D., recently at a "Recognition Day." Dr. Growt, who will soon be 70 years, has practiced 40 years at Addison. He was especially cited for sparking the drive for the first Addison hospital in 1922.

* * *

HONORED BY LIONS—Four Mt. Pleasant doctors were honored at a recent meeting of the Lions Club there. Recognized for donating time and services to examine needy children were George L. Brown, M.D., F. D. Schall, M.D., W. E. Hersee, M.D., and S. L. Chamichian, M.D.

* * *

LEADERS CHOSEN—The Michigan Society of Neurology and Psychiatry Michigan District Branch of the American Psychiatric Association has elected Eugene J. Alexander, M.D., Detroit, as president. Alvin B. Rosenbloom, M.D., Detroit, will serve as chairman of the public relations committee, and Walworth R. Slenger, M.D., Kalamazoo, as editor of the Society newsletter.

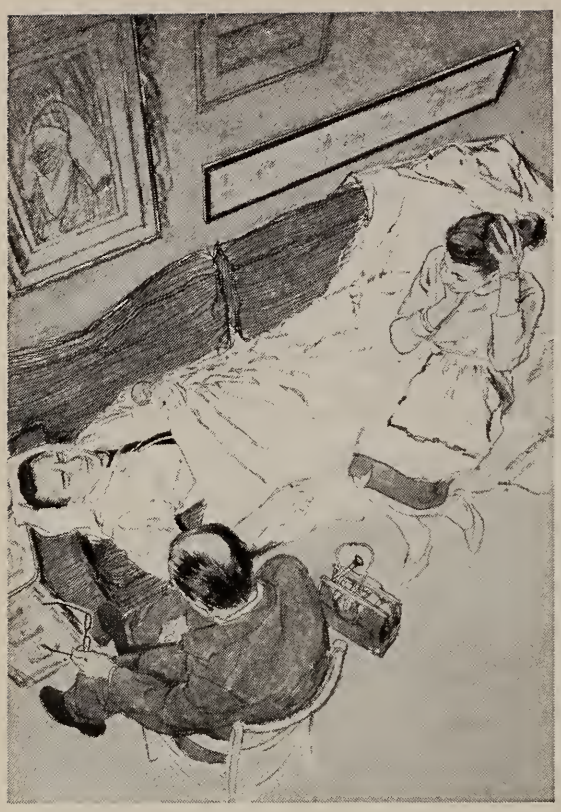
* * *

CHOSEN—The new Veterans Administration Research Advisory Committee includes Charles G. Child, III, M.D., Ann Arbor. The committee represents a consolidation of three former groups which advised the VA on medical research at the national level regarding radiobiology, radioisotopes and aging.

* * *

OFFERS GRANTS—Grants will be made for a course of study leading to a graduate degree in public health by the Michigan Tuberculosis Association, 403 Seymour Avenue, Lansing 14. The amount of the grant will be $3,500 plus $500 for each dependent as defined for income tax purposes, the total not to exceed $5,000. For further information and application forms write to the Michigan Tuberculosis Association.





DORNWAL® HAS BEEN CALLED "THE GENERAL TRANQUILIZER FOR GENERAL PRACTICE."

Suppose the physician visiting this patient finds that he has to be hospitalized. Certainly he wants an alert but not excited fellow who can respond to the history and physical on admission. Depending on the condition, of course, the thing to do is to give the patient one or two tablets of Dornwal before he ever leaves his home.

Dornwal will calm the patient but won't make him drowsy or give him feelings of depersonalization. And what's more, while Dornwal most assuredly tranquilizes, it won't interfere with most other medications that your subsequent examination or laboratory studies may indicate.

Since every man in general practice encounters such situations almost daily, it makes good sense to keep some tablets in one's bag, doesn't it? We will be glad to send you a supply.

Dosage: One or two 200 mg. tablets three times a day. Children, age 6 to 16, one or two 100 mg. tablets two times a day.

Supplied: 200 mg. yellow scored tablets, and 100 mg. pink tablets, each in bottles of 100 and 500.

P.S. For the "Genericist", Dornwal is amphenidone.

No absolute contraindications to the use of Dornwal are known. There have been no reports or evidence of habituation, addiction or drug tolerance in animal or clinical studies. Dornwal is relatively free from untoward effects when administered at recommended dosages.

Maltbie Laboratories Division,
Wallace & Tiernan Inc., Belleville 9, N. J.
PDW-12

AIDS N. H. SCHOOL—A W. K. Kellogg Foundation grant of $500,000 will enable Dartmouth College, Hanover, New Hampshire, to add a teaching auditorium adjacent to the recently constructed main building for its School of the Basic Medical Sciences. The amphitheater-type auditorium, equipped with audio-visual teaching facilities, will have a seating capacity of 400.

* * *

CO-AUTHOR—George L. Waldbott, M.D., Detroit, is co-author of a book entitled "Tratado de Allergia," an extensive monograph on the treatment of allergic diseases published in Barcelona, Spain, by Dr. F. Arasa, Edit. Cientifico Medica, 1960. The chapters on Bronchial Asthma and Contact Dermatitis were assigned to Dr. Waldbott.

* * *

AMA INVITES PAPERS—The Council on Scientific Assembly invites physicians to submit titles and brief abstracts of scientific papers they wish to deliver at the 1962 annual meeting of the American Medical Association, which will be held in Chicago, June 11-15. The deadline is October 15.

The AMA meeting in 1962 will be held in Chicago's new $35,000,000 exposition center on Lake Michigan, which has 300,000 square feet of exhibit space alone.

* * *

SUPPORTS RESEARCH—The American Cancer Society's Southeastern Michigan Division made a $50,531 grant in support of a lung cancer research project headed by Arthur Vorwald, M.D., Detroit. The grant will support Dr.

(Continued on Page 672)

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
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THESE 231,000 PEOPLE IN MICHIGAN NEED MEDICAL HELP

Heart disease, cancer, mental illness — everyone knows the nation's three major medical problems. Do you know that alcoholism ranks fourth? In the state of Michigan there are at least 231,000 alcoholics. These people need medical help. No one is in a better position to initiate and supervise a program of rehabilitation than the physician who enjoys the confidence of the patient or the patient's family.

ONE FOR THE ROAD BACK:

LIBRIUM

AN IMPORTANT AID IN THE TREATMENT AND REHABILITATION OF THE PROBLEM DRINKER

During and after an acute alcoholic episode, Librium relieves anxiety, agitation and hyperactivity, induces restful sleep, awakens the patient's desire for solid food and helps to control withdrawal symptoms. The complications of chronic alcoholism, including hallucinations and delirium tremens, can often be alleviated with Librium.

During the rehabilitation period, Librium makes the patient more accessible, strengthening the physician-patient relationship. Librium therapy helps to reduce the patient's need for alcohol by affording a constructive approach to his underlying personality disorders.

Consult literature and dosage information, available on request, before prescribing.

LIBRIUM® Hydrochloride—7-chloro-2-methylamino-5-phenyl-3H-1,4-benzodiazepine 4-oxide hydrochloride

ROCHE LABORATORIES Division of Hoffmann-La Roche Inc.

(Continued from page 670)

Vorwald's study of pulmonary cancer induced by compounds of beryllium and other test agents in experimental animals. Dr. Vorwald is interested in the fate of beryllium once it enters the bronchi of the test animals and also what happens on the biochemical level after the compound penetrates the cells.

* * *

AMA STAFF NEWS—James Reed, editor of The AMA News, has taken over the added position of director of Press Relations of the American Medical Association, succeeding John L. Bach. Mr. Bach now is the assistant director of the Department of Scientific Assembly, a newly-created post. Kenneth David, formerly with United Press, and St. Louis, Topeka, Kan., and Portland, Ore., newspapers, has joined The AMA News staff as executive editor.

* * *

RETIRES AT WSU—Marjorie J. Darrach, director of the Medical Library Service at Wayne State University for 37 years, retired April 1. Miss Darrach, 70, a native of Toronto, Ont., came to Detroit in 1918 as library assistant for the Detroit Public Library and she was appointed in 1924 as chief of the medical science department. Her successor is Vern Pings, M.D.

* * *

ARTICLE ABSTRACTED—PHARMAQUICK, published by Ames Company, Inc., of Elkhart, Indiana, has abstracted the article "Phenylketonuria In Young Infants" by Richard Allen, M.D., George Lowrey, M.D., and James Wilson, M.D., of Ann Arbor, which originally appeared in the December 1960 number of the Journal of the Michigan State Medical Society.

* * *

WORKSHOP PLANNED—A "Workshop on Rehabilitation of the Disabled Homemaker" will be held July 2-8, at Michigan State University to give training to professional persons who have the responsibility of working with disabled homemakers or establishing or supervising programs that in some way involve the rehabilitation of the disabled homemaker.

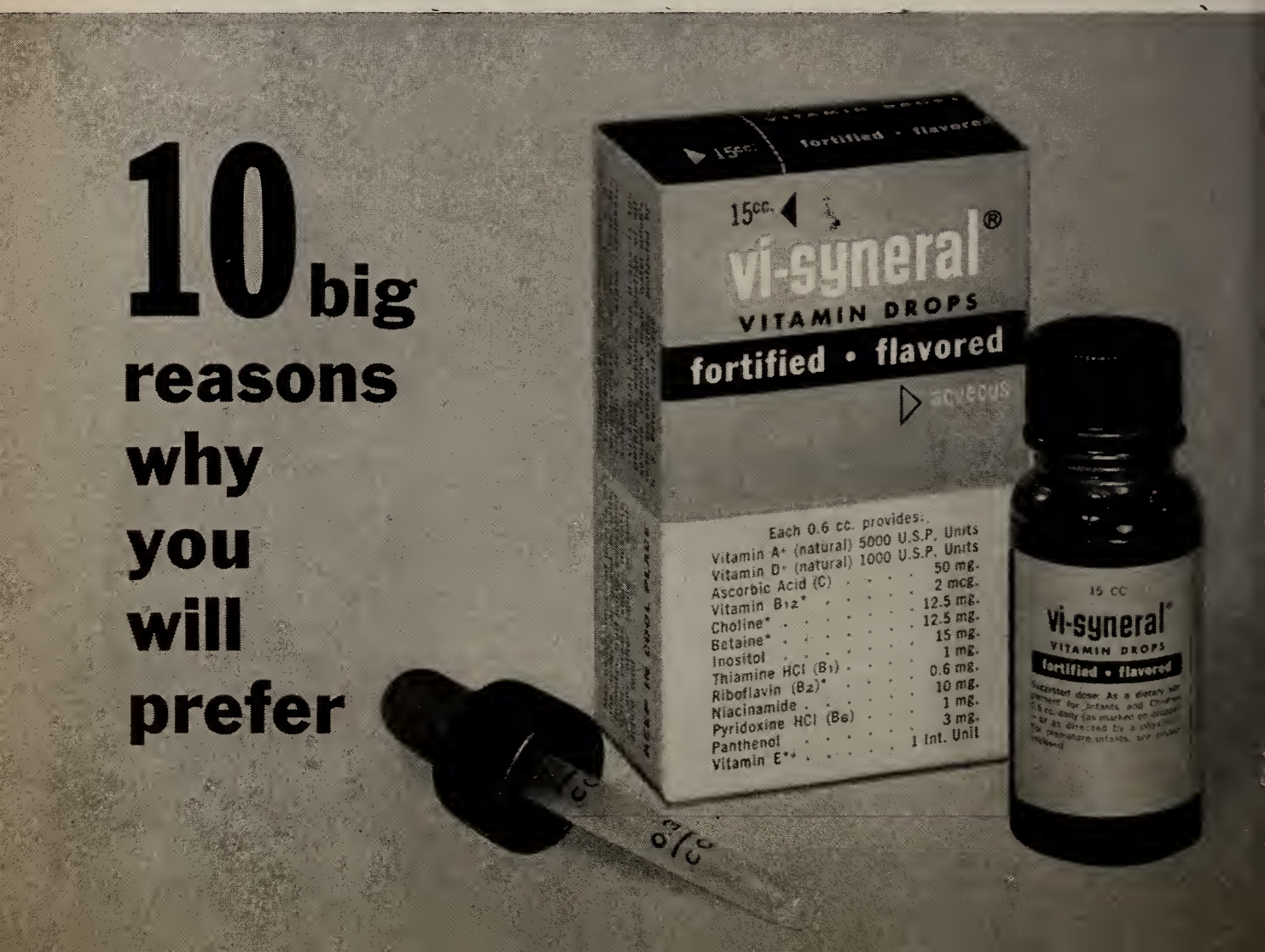
The workshop, financed by the Michigan Heart Association, is sponsored by the MSU College of Home Economics, with the co-operation of the Rehabilitation Institute of Detroit and the Rehabilitation Committee of the American Heart Association.

* * *

RECEIVES PLAQUE—The Midland Community Center presented a plaque to E. O. Barstow, M.D., Center board director, for devoted service. The appreciation plaque, in part, stated that "His leadership and spirit have been an inspiration to the entire community." Herbert H. Dow made the presentation.

* * *

U M CLASS OF 1965—The University of Michigan Medical School has selected 190 students to enter medical training in September as the Class of 1965. An additional 22 students have been chosen as alternates to fill any vacancies created by drop-outs, and to bring the total entering class to 200.



MILTON DARLING LECTURESHIP—The third annual lecture was held on "Residents' Day" at Wayne State University, March 22. Duncan E. Reid, M.D., Harvard University, was the chief speaker. Other guest speakers included C. Paul Hodgkinson, M.D., Detroit, president of the American College of Obstetricians and Gynecologists; and Harold C. Mack, M.D., also of Detroit.

* * *

WAYNE SYMPOSIUM—A two-day continuing education symposium on Rheumatology and Metabolism sponsored by Wayne State University College of Medicine was held recently. Speakers were Drs. Richard J. Bing, M. K. Keech, Newton Rottenberg, J. J. Lightbody, Herbert Rosenbaum, Alfred Klein, Joseph Hess, Joseph Shaeffer, Carl Sultzman, Charles R. Harmison, Robert B. Leach, Fred Whitehouse, Herschel Sandberg, Robert Thompson, Ivan J. Mader, Yoshikazu Morita and Richmond Smith.

* * *

FELLOWSHIPS WINNER—Bruce A. Kyburz, of Lansing, a junior at Wayne State University College of Medicine, has been awarded a $1,503 grant to spend 12 weeks at Christ Hospital, Kapit, Sarawak, Borneo. Bruce was one of 30 medical students who received foreign fellowship grants from Smith, Kline and French Laboratories, Philadelphia.

* * *

COURSES OFFERED—The University of Illinois College of Medicine Department of Otolaryngology will offer an intensive postgraduate basic and clinical program, September 23-30, and also a postgraduate course in Laryngology and Bronchoesophagology from October 23 through November 4.

* * *

REMOTELY CONTROLLED CATHETER—A remotely controlled catheter that can be directed into the human heart's cavities and passageways was developed by GM Research Special Problems department in conjunction with Richard J. Bing, M.D., Detroit. The catheter already has been used on humans and Dr. Bing has indicated it may become an important diagnostic instrument in heart disease. Although precision built, indications are it can be manufactured at reasonable cost for routine use in heart studies and diagnosis.

* * *

HONORED—George D. Zuidema, M.D., Ann Arbor, is one of 25 young medical scientists to be appointed Markle Scholars in Medical Science by the John and Mary R. Markle Foundation of New York. The Markle program seeks to help relieve the faculty shortage in medical schools by giving young teachers financial assistance. Each school receives $30,000, at the rate of $6,000 a year for the next five years, toward support of the scholar and his research.

* * *

COLORED FILMS AVAILABLE—A series of 16-mm color and sound motion pictures about various aspects of physical diagnosis is available for rental or purchase from Wayne State University College of Medicine. The project was sponsored by CIBA Pharmaceutical Products, Inc., Sum-

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mit, N. J., but none of the company's products are mentioned.

The February 4, 1961 issue of the *Journal of the American Medical Association* reviewed the films in an editorial and pointed out the "extremely useful function" of the series. It also complimented CIBA's "record of promotion of medical education programs."

All requests for showing or purchase should be directed to the Audio-Visual Utilization Center, Wayne State University, Detroit 2.

* * *

FILM OFFERED—A new tuberculin testing film, "Rancher Glen's Secrets," is now available to Michigan schools through the Michigan Tuberculosis Association and its local affiliates. This ten-minute color film features Rancher Glen, MTA's singing cowboy, and can be used to explain tuberculin testing to children in the elementary grades. The movie was produced co-operatively by Wayne State University, the Wayne County Tuberculosis and Health Society, and the Michigan Tuberculosis Association. The film is free of charge, as a Christmas Seal service. Mail requests to: Michigan Tuberculosis Association, 403 Seymour Avenue, Lansing 14.

* * *

MEDICAL MEETINGS, USA

Western Conference on Anesthesiology, Biennial, May 16-18, 1961, Sheraton Hotel, Portland, Oregon.

American College of Cardiology, Inc., May 16-20, 1961, Biltmore Hotel, New York, N. Y. Philip Reichert, M.D., 350 Fifth Ave., Empire State Bldg., New York 1, Executive Director.

(Continued on Page 676)

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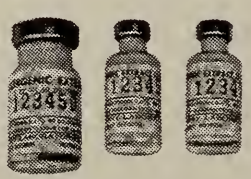
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(Continued from Page 674)

American Association of Plastic Surgeons, May 17-19, 1961, Commodore Hotel, New York City. Thomas D. Cronin, M.D., 6615 Travis St., Houston 25, Texas, Executive Secretary.

American Association for the History of Medicine, May 18-20, 1961, Shoreland Hotel, Chicago. John B. Blake, c/o Smithsonian Institution, Washington 25, D. C., Secretary-Treasurer.

American Laryngological Association, May 21-22, 1961, Lake Placid Club, Lake Placid, N. Y. Lyman G. Richards, M.D., 12 Clovelly Rd., Wellesley 81, Mass., Executive Secretary.

American Thoracic Society, May 22-25, 1961, Netherland-Hilton, Cincinnati. Frank W. Webster, 1790 Broadway, New York 19, Executive Secretary.

Minnesota State Medical Association, 108th Annual, May 22-24, 1961, St. Paul Municipal Auditorium. 496 Lowry Medical Arts Bldg., St. Paul.

American Orthopaedic Association, May 22-25, 1961, The Ahwahnee, Yosemite, Calif. Lee Ramsey Straub, M.D., 535 E. 70th St., New York 21, Secretary.

American Urological Association, May 22-25, 1961, Biltmore Hotel, Los Angeles, William P. Didusch, 1120 N. Charles St., Baltimore 1, Executive Secretary.

National Tuberculosis Association, May 22-25, 1961, Netherland-Hilton, Cincinnati, James G. Stone, 1790 Broadway, New York 19, Executive Secretary.

(Continued on Page 678)

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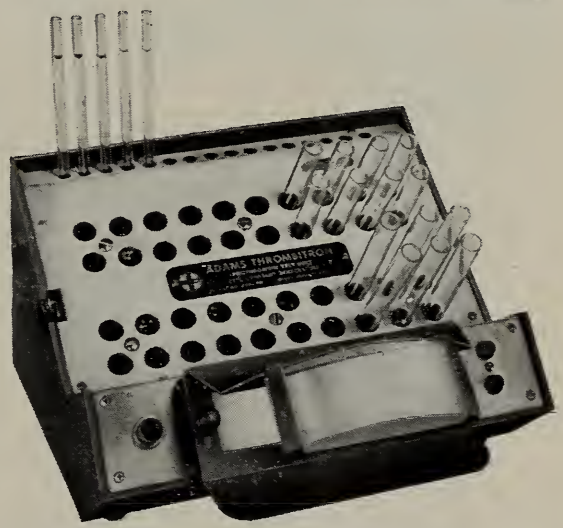
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(Continued from Page 676)

American Laryngological, Rhinological and Otological Society, Inc., May 23-25, 1961, Lake Placid Club, Lake Placid, Essex Co., N. Y. C. Stewart Nash, M.D., 708 Medical Arts Bldg., Rochester 7, N. Y., Secretary.

American Gastroscopic Society, May 24, 1961, Drake Hotel, Chicago. Arthur M. Olsen, M.D., Mayo Clinic, Rochester, Minn., Secretary.

American Gastroenterological Association, May 25-27, 1961, Drake Hotel, Chicago. Wade Volwiler, M.D., Dept. of Med., Univ. of Washington, Seattle 5, Secretary.

American Otological Society, Inc., May 26-27, 1961, Lake Placid Club, Essex County, N. Y. James A. Moore, M.D., 525 E. 68th St., New York 21, Secretary-Treasurer.

Trudeau School of Tuberculosis and Other Pulmonary Diseases, Forty-sixth Session, June 5-23, 1961, Saranac Lake, N. Y. For information write to the Secretary, Trudeau School of Tuberculosis and Other Pulmonary Diseases, Box 670, Saranac Lake, N. Y.

American Electroencephalographic Society, June 8-11, 1961, Hotel Claridge, Atlantic City, N. J. George A. Ulett, M.D., Malcolm Bliss Mental Health Center, 1420 Grattan, St. Louis 4, Executive Secretary.

American Neurological Association, June 12-14, 1961, Hotel Claridge, Atlantic City. Melvin D. Yahr, M.D., Neurological Institute, 710 W. 168th St., New York 32, Executive Secretary.

Society of Nuclear Medicine, June 14-17, 1961, Penn Sheraton Hotel, Pittsburgh. Samuel N. Turiel, 430 N. Michigan Ave., Chicago 11, Executive Administrator.

American Dermatological Association, June 16-20, 1961, Castle Harbour Hotel, Tucker's Town, Bermuda. Wiley M. Sams, M.D., 25 S.E. Second Ave., Miami 32, Fla., Secretary.

American Proctologic Society, June 21-24, 1961, Pittsburgh Hilton Hotel, Pittsburgh. Norman D. Nigro, M.D., 10 Peterboro St., Detroit, Secretary.

American Geriatrics Society, June 22-23, 1961, New York City. Richard J. Kraemer, M.D., 2907 Post Rd., Greenwood, Warwich, R. I.

American Rheumatism Association, June 22-23, 1961, Hotel Roosevelt, New York City. Gerald W. Speyer, 10 Columbus Circle, New York 19, Executive Secretary.

Endocrine Society, June 22-24, 1961, Hotel Biltmore, New York, N. Y. Henry H. Turner, M.D., 1200 North Walker, Oklahoma City 3, Secretary.

American Therapeutic Society, June 22-25, 1961, Essex House, New York City. Oscar B. Hunter, Jr., M.D., 915-19th St., N.W., Washington 6, D. C., Secretary.

American College of Chest Physicians, June 22-26, 1961, Hotel Commodore, New York City. Murray Kornfeld, 112 E. Chestnut St., Chicago, Executive Director.

American College of Angiology, June 23-25, 1961, Savoy-Hilton Hotel, New York City. Alfred Halpern, Ph.D., 11 Hampton Court, Great Neck, N. Y., Secretary.

American Academy of Tuberculosis Physicians, June 24, 1961, Henry Hudson Hotel, New York City. George P. Bailey, M.D., P.O. Box 7011, Denver 6, Colorado, Secretary.

American Diabetes Association, Inc., June 24-25, 1961, Commodore Hotel, New York City. J. Richard Connelly, 1 E. 45th St., New York 17, Executive Director.

(Continued on Page 680)



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(Continued from Page 678)

Association for Colon Surgery, June 25, 1961, Barbizon-Plaza Hotel, New York, N. Y. Robert Turell, M.D., 25 East 83rd St., New York 28, Secretary-Treasurer.

Society for Vascular Surgery, June 25, 1961, Biltmore Hotel, New York City. George H. Yeager, M.D., 314 Medical Arts Bldg., Baltimore 1, Secretary.

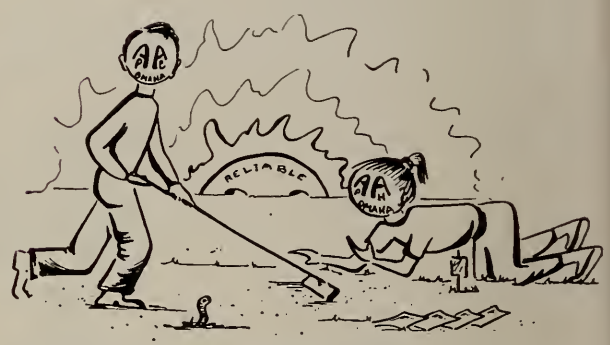
American Medical Association, Annual Meeting, June 25-30, 1961, New York City. F. J. L. Blasingame, M.D., 535 N. Dearborn, Chicago 10, Executive Vice-President.

American Physicians Art Association, June 26-30, 1961, New York City. Alfred A. Richman, M.D., 307 Second Ave., New York 3, Executive Secretary.

Society for Investigative Dermatology, June 27-29, 1961, Barbizon-Plaza Hotel, New York City. Herman Beerman, M.D., 255 S. 17th St., Philadelphia 3, Secretary-Treasurer.

American Society of Facial Plastic Surgery, June 28, 1961, Hotel Elysee, New York. Samuel M. Bloom, M.D., 123 E. 83rd St., New York 28, Secretary.

American Physical Therapy Association, July 2-7, 1961, Palmer House, Chicago. Lucy Blair, 1790 Broadway, New York 19, Executive Director.



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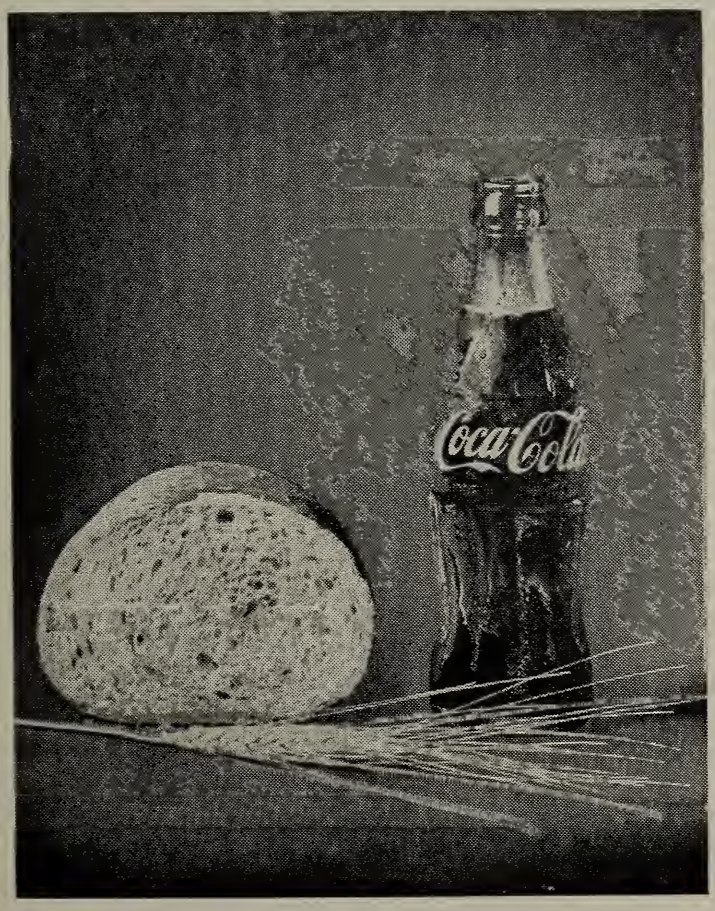
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Michigan Authors

Joseph W. Hess, M.D., Detroit, "Lead Encephalopathy Simulating Subdural Hematoma in an Adult," *The New England Journal of Medicine*, February 23, 1961.

Paul U. Fechner, M.D., and **Ina Fechner, M.D.,** Ann Arbor and Eloise, "Influence of Pyrogen on Healing of Corneal Ulcers," *Archives of Ophthalmology*, March, 1961.

John A. Meyer, M.D., David A. Blumenstock, M.D., and **Frederick B. Berry, M.D.,** Ann Arbor, "Procainamide Hydrochloride in Ventricular Defibrillation," *Archives of Surgery*, March, 1961.

Frederick H. Epstein, M.D., Ann Arbor; **Joseph T. Doyle, M.D.,** Albany, N.Y.; **Albert A. Pollack, M.D.,** New York City; **Herbert Pollack, M.D., George P. Robb, M.D.,** and **Ernst Simonson, M.D.,** Minneapolis, "Observer Interpretation of Electrocardiograms," *Journal, American Medical Association*, March 11, 1961.

Hermann Pinkus, M.D., Detroit, "Postinflammatory Hair Darkening," *Archives of Dermatology*, August, 1960.

Renato G. Staricco, M.D., Detroit, "The Melanocytes and the Hair Follicle," *Journal of Investigative Dermatology*, September, 1960.

Hermann Pinkus, M.D., Detroit, "Four-Dimensional Histopathology," *Archives of Dermatology*, November, 1960.

Hermann Pinkus, M.D., and **Rosie Hunter,** Detroit, "Simplified Acid Orcein and Giemsa Technique for Routine Staining of Skin Sections," *Archives of Dermatology*, November, 1960.

Amir H. Mehregan, M.D., and **Hermann Pinkus, M.D.,** Detroit, "Necrobiosis Lipoidica with Sarcoid Reaction," *Archives of Dermatology*, January, 1961.

Herschel S. Zackheim, M.D., Royal Oak, and **Hermann Pinkus, M.D.,** Detroit, "Perifollicular Fibromas," *Archives of Dermatology*, December, 1960.

Thomas W. Kavanagh, M.D., and **Richard C. Parsons, M.D.,** Battle Creek, "An Unusually Large Mixed Tumor of the Parotid," *The Laryngoscope*, January, 1961.

E. A. Shaptini, M.D., Ann Arbor, "Byssinosis—A Review," *Industrial Medicine and Surgery*, March, 1961.

Frederick C. Swartz, M.D., Lansing, "What is Aging?," *Industrial Medicine and Surgery*, March, 1961.

Herbert Rosenbaum, M.D., and **William S. Reveno, M.D.,** "Subacute Thyroiditis—Difficulties in Diagnosis and Treatment," *Harper Hospital Bulletin*, January-February, 1961.

G. Nigogosyan, M.D. and **John R. McDonald, M.D.,** Detroit, "Occurrence and Significance of Tumor Cells in the Blood," *Harper Hospital Bulletin*, January-February, 1961.

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IN MEMORIAM

FRANK O'BRIEN CONNOLLY, M.D., fifty-nine, Pleasant Ridge physician, died February 26, 1961.

Born in Austria, Doctor Connolly came to the Detroit area forty-five years ago. He was graduated from the University of Detroit, and Wayne State University College of Medicine. He served his internship at Providence Hospital, Detroit, and was on the staff of Mt. Carmel Mercy Hospital, Detroit.

Doctor Connolly was a fellow of the American College of Surgeons, and an active member of the Michigan State Medical Society.

RICHARD M. McKEAN, M.D., sixty-five, Detroit physician for forty years, died March 20, 1961.

A nationally known specialist in internal medicine, he was a 1919 graduate of the University of Michigan medical school. He served in World War II as a colonel with the 36th General Hospital in the Mediterranean and European theaters and was awarded the Legion of Merit.



R. M. McKEAN

He was a professor at Wayne State University College of Medicine. Professional affiliations included the American College of Physicians and the Royal Society of Medicine, and he was past president of both the Detroit Academy of Medicine and the Detroit Medical Club. For years, he served as a member of the progressive Postgraduate Medical Education Committee of MSMS.

Doctor McKean was a member of the Detroit Club, University Club and was a past member of the board of governors of the U. of M. Club. He was a director of the Detroit Citizens League.

HAZEL RUTH PRENTICE, M.D., sixty-two, Kalamazoo pathologist since 1929, died March 18, 1961.

Doctor Prentice served as pathologist and director of the laboratory at Bronson Hospital for nearly thirty years, until her retirement in 1958. She came to Kalamazoo in 1929, after receiving her medical degree at the University of Michigan and interning in Philadelphia.

Born in Worcester, Massachusetts, she graduated from Smith College in 1919.

She was a past president of the Michigan Pathological Society, past president of the Kalamazoo Women's Business and Professional Women's Club, and a member of Phi Beta Kappa.

DELMA F. THOMAS, M.D., seventy-two, Detroit physician for nearly forty years, died March 20, 1961.

Doctor Thomas came to Detroit in 1913, three years after graduating from the University of Denver. She graduated from Wayne State University College of Medicine in 1922.

Doctor Thomas was a life member of the Michigan State Medical Society, a member of the Professional Women's Club, and long acted as house doctor for coeds at the University of Detroit.



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THE COVER

The cover design graphically illustrates the relationship between medicine, the general public and Michigan Medical Service as this number helps to tell the Blue Shield story.

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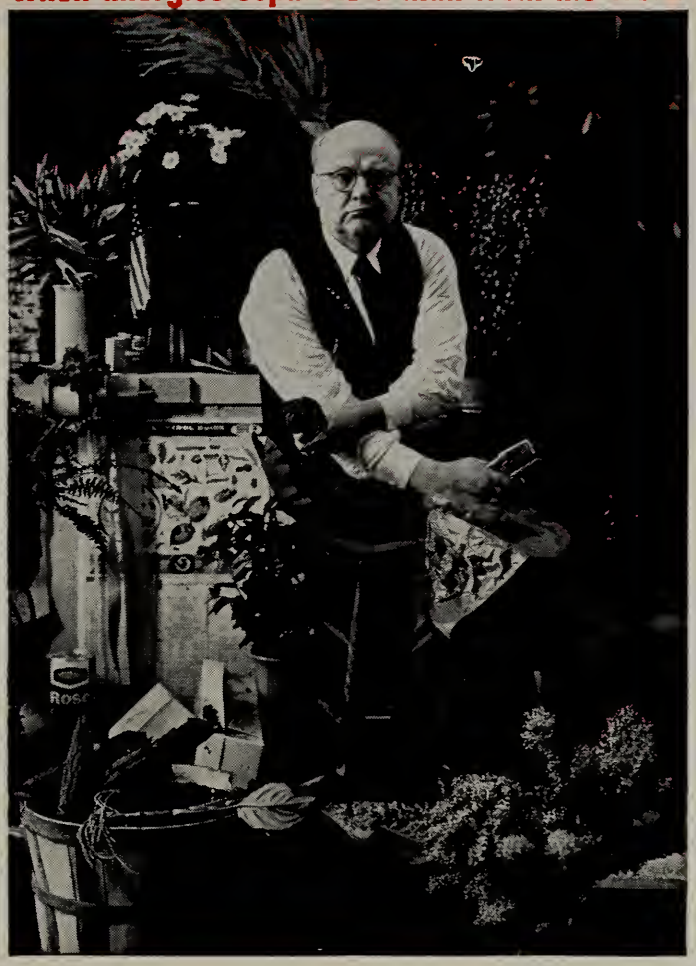
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President's Page

ON THE SPOT!



Kenneth H. Hansen

President

Michigan State Medical Society

I write this page with sincerely mingled feelings. In the first place, I still practice medicine which is my first love. In the second place, by the time this is printed, the new headquarters building in East Lansing will have been dedicated. Dedicated to service for the citizens of Michigan from the Michigan State Medical Society. Third—I have just returned from Washington, D. C., where I, along with six others from MSMS, and Sumner Whittier of Blue Shield, tried to appraise the political situation on the national level.

I have never had an answer from any President's Page to date. My so-called "angry" letter at least got some reaction—both for and against. I, therefore, wonder whether this message will reach the doctors of Michigan. I can only hope it will.

Let me go back now and pick up my mingled feelings. Regardless of who he is or what he does as a practicing physician, once one assumes the responsibilities of political medicine, he will have to pay for it in time, energy and money, whether it be a success or failure. He can not be misled by thinking he can do both well. He must sacrifice one or the other. Therefore, it is most important that nothing be sacrificed for personal vanity. Physicians who carry the ball—politically—do so at great personal sacrifice.

The new headquarters for MSMS is one of the most beautiful buildings you will ever see. Most importantly, it is a very real challenge to every physician in Michigan to realize that he has a destiny with the present and the future. Not only will this building be used by the individual components of the MSMS, but it will be a rallying point for many organizations which have important contributions to make to the health and welfare of the people of this state.

Now, I want to say something to you, as physicians—as a result of my recent experience.

The situation in Washington is in the nature of a political deal—no more, no less. There is no intellectual evaluation being used to decide the issues. One of our most helpful interviews was from a Democrat who flatly stated that he agreed with us, but would have to vote for the administration bill because he had no other choice. There is no chance to argue against this situation; it is his political life or oblivion.

The physicians of this country, whether we are represented by the AMA, the MSMS or any county medical society are on a spot. We have no other choice but to stick together. It matters little as to whether you are a surgeon, an internist, an obstetrician, a pediatrician, a plastic surgeon, an orthopedist, an anesthesiologist, a urologist, a psychiatrist, or a general practitioner—we are either together or we are nothing! In addition, whatever our individual feelings are concerning Blue Shield, we have no other choice but to make it work. It is our best answer to the democrats, the socio-economist, the unionist, the politician who would try to usurp our prerogatives as physicians. I would say as I view the picture after my recent trip—everyone of you should go to Washington in order to personally see what I mean. But if you cannot; take my word for it, there is no other choice before us but to put all our energy into keeping Blue Shield solvent and workable.

Thousand Attend MSMS Dedication



The new headquarters building of the Michigan State Medical Society was dedicated June 4 at East Lansing with approximately 1,000 doctors and friends participating in the program and open house.

It was an impressive affair—with many challenges presented to the Michigan doctors of medicine to improve and expand their services to the public. And there were assurances by medical spokesmen that these opportunities are being met now and will be tackled with new vigor in the future from the headquarters building.

* * *

THE DEDICATION WEEK-END activities began June 3 with the meeting of The MSMS Council. Ceremonies on June 4 began with the flag-raising ceremony at 2:45 p.m., followed by the dedication program at 3 p.m. from a platform at the rear of the building.

Selected officials of MSMS and several past presidents participated in the flag-raising ceremony. A color guard of the Michigan National Guard hoisted the flag, presented by Congressman Charles Chamberlain. The flag formerly flew over the Capitol in Washington, D. C.

The dedication ceremony was called to order by William S. Jones, M.D., of Menominee, a past MSMS president and chairman of the Big Look Committee. He presented President Johnson, who in turn introduced the dignitaries at the speakers' platform. Dr. Johnson presented a short address, "The Past is Prologue" and E. Vincent Askey, M.D., of California, AMA president, gave a speech, entitled "The House that Medicine Builds."

* * *

FOLLOWING THE PROGRAM, the spectators were invited to tour the building.

Members of the MSMS House of Delegates were honored guests for the day, and their names were listed in the dedication program booklet. Members of The Council served as guides during the open house.

Members of the Woman's Auxiliary to MSMS were hosts in the Conference-Dining Room, where they maintained a guest-registry book.

AMA President Askey Says Headquarters a Place For Answers, Decisions

Following are some excerpts from the dedicatory address given by E. Vincent Askey, M.D., AMA president, at the June 4 dedication of the new MSMS headquarters building:

"To me Michigan medicine and Michigan physicians have erected a headquarters that signifies service to the public and to the profes-

sion and untold contributions to society. The architecture expresses to me that the men and women of medicine who have been a part of this building campaign are leaders and doers with vitality, devotion and resolution.

"I see this grand building as a place for solving problems, for disseminating public and professional education and information, for reliable decisions in the best interests of the public and medicine, and for promoting the best in the art and science of medicine and the betterment of the public health.

"Here is a structure that expresses the confidence, knowledge and foresight of the medical profession. Here is a headquarters that beckons to all in clear ringing voice: 'Bring me your problems, your woes and your dilemmas, and they will be resolved within these walls by the dedicated men and women housed herein.'

"Yes, this is a headquarters building which will be a house of solutions, answers and decisions, not a house of secrets, doubts and indecisions.

Facts and Truths Assured

"From here will go out medical truths and facts, not distortions and fraud. Here will be found the keys to better public understanding of the medical profession. From here will go the latest medical information to physicians and to the public. And here both the profession and the public will get further medical and health education.

"This is the house that Michigan medicine has built—a place where problems are resolved not created; a place where difficult issues are explained not twisted; a place where reliable help and assistance is offered to profession and public alike.

"This new headquarters of the Michigan State Medical Society built on the solid foundation of concrete, stone and steel has an even more substantial foundation. And that base of rock is the personal service, devotion and medical care provided by every Michigan physician to every patient that he sees.

Doctor-Patient Role Important

"The 'heart' of that foundation has been, and still is, the devotion of physicians to patients, the competence to handle the problems of the individual patient, and the completely ethical manner in which each physician carries out his role in the doctor-patient relationship.

"These are the elements of good medical practice. And these, plus the medical society's unceasing efforts to guarantee medical care for all regardless of their ability to pay and its deep concern with the problems of the financially needy, the aged, community health and safety, disease detection, doctor placement and supply, emergencies, medical facilities, quacks and fads, school health, rural health, occupational health, and a hundred other items, have resulted in a great and growing public confidence and trust in the physician and the medical society.

"As President of the American Medical Association, I am delighted to know that the Michigan State Medical Society has a unique five-year Presidents Program aimed at increasing the potential productivity and usefulness of additional years of life. And I am happy to know that in this new headquarters the first major project will be the implementation of this wonderful program.

"Projects of this kind are the blocks of granite by which a respected, resourceful and resolute medical society builds a better and more healthful life for the people physicians serve.

MSMS on Health Team

"Let no man or woman here today, whether it is in medicine, business, labor, government or any other pursuit, think for one minute that a medical society functions for physicians only, or for the profession only. This society and this headquarters, just like every other state and county medical society and the American Medical Association, are integral parts of the health team of this state and of our nation.

"Their roles are vital to the individual's health, the community's health and the nation's health."

MSMS President Sees Greater Efficiency

Following are excerpts from the June 4 address of MSMS President Johnson:

"The Michigan State Medical Society is in its 96th year. We who are the representatives of our profession within the framework of this Society are proud of the past 95 years. Its members have been credited with many individual achievements and collectively have been responsible for many firsts among the State Societies of the country. In addition, the Society has conscientiously striven to accept and adapt to its own situation ideas from many other groups.

"We believe that this has been done with integrity, soberly applied aggressiveness, and somewhat more than ordinary success. The total effect of these efforts, which I shall not spend time enumerating, have provided the citizens of this State with improved health and general welfare.

"Our efforts here have been not only in the field of medical science but also in areas of social improvement and economics. The Michigan State Medical Society has been the 'family doctor of the people of Michigan,' always willing to refer to specialists in their field when the need has arisen, but collectively aware of the requirements of all for these many years.

"In addition to the vast number of activities now

operational and which will be more adequately fulfilled here, there are programs and plans not yet completely activated which will be put into operation as soon as possible.

Presidents Program Unlimited

"The most significant immediate idea which will be put into operation, and in fact is already operating, in connection with this headquarters building is the Presidents Program of the Michigan State Medical Society.

"It is unlimited in its scope. I have been much impressed by the enthusiastic response this idea has elicited. In this day when our news is so full of tragedy or threats of tragedy, we need ideas like this to make us work for better things. We believe this is such a plan—and we are proud to speak of it at this particular occasion, since our headquarters building will be the control center of the program.

"While the Presidents Program will be a number one project during the next five years, we are no less intent in our purpose to continue to improve our work in all areas.

To Seek Greater Cohesion

"Since the State Society exists only because of and is controlled by the component county medical societies, our new headquarters will provide an opportunity to identify this relationship more closely. Undoubtedly, there will also ensue a better contact between county medical societies, thus making for greater cohesion.

"We sincerely believe its facilities will provide for greater efficiency by the staff and increasing satisfactory performance by the various functioning elements of the State Society, to the end that all of us shall be healthier and happier.

Photos Later

Photographs taken at the June 4 MSMS dedication will appear in the July issue of THE JOURNAL. The June issue was held up several days in order to include this timely report of the dedication.

Congratulations!

Dear Doctor Johnson,

Sincerely regret my schedule will not permit my presence this afternoon at the dedication ceremonies of the Michigan State Medical Society's new headquarters. Personal good wishes to all attending this fine affair for a most memorable afternoon.

JOHN B. SWAINSON, *Governor*

* * *

Dear Doctor Johnson,

Much to my regret, I shall not be able to accept your kind invitation to join you at the dedication of your new headquarters building on Sunday, June 4.

The spectacular advances made in medicine reflect dramatically the devotion of dedicated men and women in the profession. I am delighted that you will have this new building, and add my congratulations to the many I know you are receiving.

PHILIP A. HART, *Senator*

* * *

Dear Doctor Johnson,

I wish very much that I could join you and your guests tomorrow for the dedication of the new Michigan State Medical Society headquarters, but it is not possible for me to be in Michigan this weekend. I know you are proud of your new building and its symbol of progress within your Society, and I look forward to visiting the headquarters soon. Please extend my best wishes and warm congratulations to the members of the Society.

CHARLES E. CHAMBERLAIN, *Member of Congress*

* * *

Dear Doctor Johnson,

The Chamber of Commerce of the United States congratulates you and the Michigan State Medical Society upon the dedication of your new headquarters building. We wish you the greatest successes in your service to the people of Michigan and the improvement of medical care for all people. It is a privilege to be associated with you in this important work of building a prosperous and free nation.

RICHARD WAGNER, *President*
United States Chamber of Commerce

MICHIGAN MEDICAL MEETINGS AND CLINIC DAYS

July 27-28	Coller-Penberthy Clinic	Park Place Hotel, Traverse City
Sept. 27-28	Michigan State Medical Assistants Society	Pantlind Hotel, Grand Rapids
Sept. 27-28	Woman's Auxiliary to MSMS	Occidental Hotel, Muskegon
Sept. 27-29	MSMS Annual Session	Pantlind Hotel-Civic Auditorium, Grand Rapids
Sept. 29-30	"Doctors' Day"	University of Michigan, Ann Arbor

MSMS Studies McNerney Reports

The reports being issued by the Michigan Study of Hospital and Medical Economics, a University of Michigan project for the Governor's Commission on Prepaid Hospital Plans, are being studied by The MSMS Council and several MSMS committees.

The first three of the thirteen different studies were released May 14, and the balance will be explained by Professor Walter J. McNerney, project director, at news conferences in June. A preliminary session with 65 representatives of MSMS, MMS, MHS and the Michigan Hospital Associations was held April 27.

Circuit Judge George E. Bowles, chairman of the Governor's Commission, reports that the Commission will study the recommendations and detailed information during the summer and make its recommendations to the Governor in the fall.

Chairman Bowles has declared, "We are constituted to help, not to condemn, and through our broad charge hope to make recommendations and to win the enlightened cooperation of interested groups."

The study has been financed by grants of $380,000 from the Kellogg Foundation. The study reportedly is the largest independent analysis yet made of hospital and medical economics in the nation. The work began three years ago. The completed report will be published (1,600 pages) under the title, "Hospital and Medical Economics," by the Hospital Research and Educational Trust, Chicago.

Blue Cross-Blue Shield Announcement

During the next three months, enrolled members of your Professional Association (in Groups No. Series 94,000) will receive printed material from Blue Cross-Blue Shield, which will give subscribers an opportunity to: 1. Change coverage to a Deductible Program; 2. Make other changes in Blue Cross-Blue Shield coverage.

MEMBERS OF YOUR ASSOCIATION NOT NOW ENROLLED FOR GROUP COVERAGE may obtain an application and a folder, describing the coverage available to them, by calling or writing the nearest Blue Cross-Blue Shield District Office or by writing the Special Accounts Department, Blue Cross-Blue Shield Building, 441 East Jefferson Avenue, Detroit 26, Michigan

Dr. Payne Honored

C. Allen Payne, M.D., Grand Rapids, MSMS Councilor, was honored recently by the American Cancer Society at a Grand Rapids meeting when he was presented a National Divisional Award for Distinguished Service. Doctor Payne is a member of the Michigan Division Executive Committee and the Board of Directors and also represents the division as a professional delegate. He also represents his division on the Michigan Cancer Coordinating Committee.

Report on Visit to Congress

The following report was made to The Council by those constituting the Michigan delegation who visited Congress April 30-May 3, 1961:

We are utterly convinced that

1. Action to solidify opposition against some form of socialized medicine is needed *immediately*;
2. The problem is clearly national in scope—every single congressman is a key man;
3. Michigan *representation in Washington*, at this time, is justified to hold every possible vote for medicine;
4. *Local action* through 10-10-10, regional meetings, et cetera, must be correlated with point 3 above and go forward with dispatch; and
5. *Every physician* must *support* the *Blue Plans* as a major defense against socialized medicine.

We are of the unanimous opinion that our visit with the Michigan congressmen in Washington, D. C., was of great mutual value, and unreservedly recommend that the congressional visitations be continued on an annual basis. For our part, the experience brought many major aspects of the current situation into focus and gave us valuable insights as to the complex problems and attitudes of our congressmen; on the other hand, *all* of our congressmen made it very clear that they appreciated our interest in them as evidenced by the visit.

K. H. Johnson, M.D.
L. A. Drolett, M.D.
C. Allen Payne, M.D.
R. J. Mason, M.D.
J. R. Dehlin, M.D.
H. W. Brenneman
M. A. Riley

Communication Potentialities of the Printed Word

By JEAN WORTH, Editor, *Escanaba Daily Press*

(First of several installments of a paper presented before the 1961 MSMS County Secretaries-Public Relations Seminar)

Any early belief that the conquest of the contagious diseases would cause a surplus of physicians and, inevitably, of money saved on doctor bills, has been long dispelled.

Any early belief that the brave new world of science with its marvels of instantaneous transmission of thought would solve our problems of communication is also dead.

Change has a habit of bringing along its own problems. Where a prime problem of communication long was quick transmission, now it is understanding of the great mass of matter so quickly transmitted.

* * *

IT IS NOW POSSIBLE to photograph the "back side" of the moon from a satellite, to go around the world underwater and to perform surgery on the human heart. These are rather recent developments. But not many years ago I reported the speech of a Michigan mayor who opposed expenditure of tax money on a sewage disposal plant because he was certain that cooking in aluminum utensils, and not germs in water borne sewage, menaced public health.

Literacy in Michigan is very high—almost complete, some of the optimists among us believe. We have never had such a production from the presses, so much newspaper circulation, so many books, nor so many radio broadcasts nor so much television programming. The new Michigan State Plan for Libraries aims to provide library service for everyone in Michigan.

Close to the eye, the picture is one to gladden the heart and make us believe, like Pippa, that all's right with the world. But our ability to read the printed word that flourishes everywhere brings us some disquieting information.

In Wisconsin last fall, when the people of our neighboring state were endorsing brave new frontiers in national politics, there were referenda in many cities on the fluoridation of public water supplies. In nearly all the cities voting, the proposal was defeated.

This method of assisting nature to reduce decay in children's teeth has been presented to the public as extensively researched and recommended by the American Dental Association, the American Medical Association, the U. S. Public Health Service and other organizations qualified to comment.

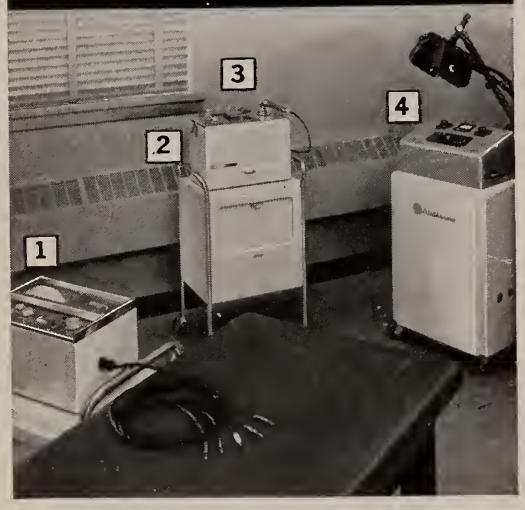
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THE PUBLIC HAS been told that there are not enough dentists to care for all the dental work needed if it is all undertaken. Fluoridation is a safe means of reducing this need; of increasing dental health. The people were exposed to much information and misinformation on this issue and, in the exercise of their franchise as free citizens in this age of scientific medicine and scientific communications they rejected fluoridation.

This might be understandable if it had happened at Siskiwit

Burdick

electronic aids for diagnosis and treatment



With the advances and new technics in electronics as applied to medicine, efficient and practical equipment is now available for general office use—

1 **EK-III Dual-Speed ELECTROCARDIOGRAPH** — Lightweight, portable, accurate, simple to operate. 25 mm.- or 50 mm.-per-second speeds.

2 **UT-400 PULSED ULTRASONIC UNIT** — Continuous or pulsed energy. Compact, portable, six sq. cm. radiating area.

3 **MS-300 MUSCLE STIMULATOR** — Ideal for stimulation of innervated muscle tissue. Can be used in combination with the UT-400, as illustrated above.

4 **MF-49 SHORT WAVE DIATHERMY** — Versatile. Used with every type of diathermy electrode.

Complete information — including specifications and prices — on all Burdick electromedical apparatus is readily available from your local Burdick representative, or write directly to The Burdick Corporation, Milton, Wisconsin.

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4444 Woodward Avenue, Detroit 1, Michigan

Telephone: TEmple 1-6880

Harbor, Isle Royale, which is not much jarred by scientific change, but the city of Manitowoc, population about 30,000, where they make modern submarines, was among the cities which vetoed science.

In Michigan, our angry sportsmen are about to pressure the State Legislature to take scientific control of the deer herd away from the Conservation Department's biologists. The hunters are irked because there were fewer deer to shoot last fall than the fall before. That there would be fewer and that there may be fewer still next fall had been forecast by informed persons, because the large deer herd has seriously depleted its range feeds.

This is another rejection of the scientific method of research, discovery and remedy. These incidents are leaves in the wind of public opinion that show some serious misdirections.

Nor are they isolated instances. The Committee on Science in the Promotion of Human Welfare of the American Association for the Advancement of Science warns that "a growing disparity between scientific progress and the resolution of the social issues which it has evoked threatens to disrupt the history of man."

* * *

PUBLIC IGNORANCE, together with the growing importance of science as a military and political instrument, threatens to erode the integrity of science itself, the Committee states in urging scientists to acquaint themselves and the public at large with the technical aspects of pressing issues. And it asks scientists to accept the obligation to determine how new scientific advances are likely to affect human welfare and to call these matters to public attention.

The need for such action is becoming increasingly apparent as public understanding lags behind scientific advance, but its correction will not be simple nor easy. The mechanical and electronic means for the needed communication exist, but obviously they are not performing the task adequately.

* * *

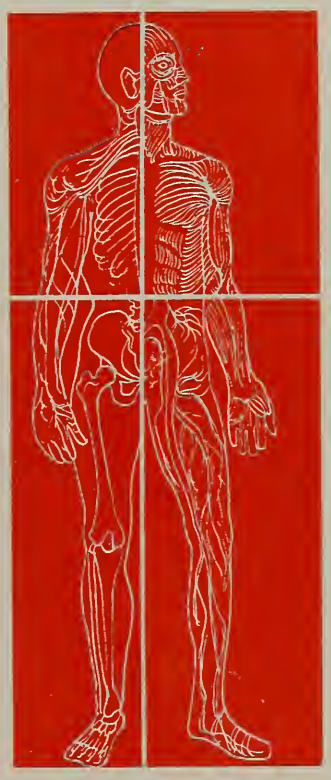
ALL DOCTORS OF MEDICINE MUST be hyperconscious of this condition as they watch the trend toward government medicine. What they may not be so conscious of is their contribution, or lack of it, to the trend.

My assignment for comment in this workshop on public relations is the printed word. Wisdom doesn't necessarily come out of nearly 40 years of earning a living by the printed word, but certainly some familiarity should.

An American male baby born today can look forward to a working lifetime of 42.3 years—11.2 years longer than the working-life expectancy of a male baby born at the start of this century.

Use of Analeptic, Anti-Depressant And Anabolic Drugs In Treatment of the Aged

Benjamin O. Morrison, M.D.
New Orleans, Louisiana



THE LENGTH in life span and the tensions of urban modern living have directed medical attention to the nature and treatment of degenerative diseases. Physicians see a steadily increasing number of geriatric patients. There is no universally effective method of treating the symptoms of senility.[1] However, there are three popular methods: treatment with analeptics, treatment with anti-depressants, and the use of anabolic type drugs. The apparent mechanism of action of the analeptic drugs is the stimulation of the central nervous system to overcome depression.[2] However, analeptics alone may be adequate in the treatment of central nervous system depression. In those cases of severe depression not helped by this type of drug, the geriatrician or practicing physician has at his disposal the far-reaching effect with steroids (Panogen) on the integrity of various body tissues.[3] This article is not concerned with weighing the merits of one product or one method against another; however, because it is important to integrate these types of drugs to the best interest of the patient, it is advisable to mention, in brief, the indications and the results of therapy with each one of these three types of agents.

First, the Metrazol compound with vitamins and with nicotinic acid has been used by many of the earlier and distinguished geriatricians in this field. Chesrow and his colleagues[4] were able to prove that a group of twenty-six out of thirty-two aged people responded favorably to oral Metrazol. Later reports by Smigel[5,6] and Kass[7] are favorable also and the side effects are reported as few and never serious. These findings compare favorably with those of this investigator.[1] Handley and colleagues[8] found that Metrazol increased glycogen and glucose utilization by the brain, probably by increasing the permeability of cell membranes to normal levels and beyond. Although the mode of action of Metrazol is not understood precisely, it appears to stimulate respiration and, indirectly, circulation by acting upon the medullary centers and, to a lesser extent, on the cerebral cortex and on the entire central nervous system (CNS).[9,10] This action is especially pronounced when the medullary centers are depressed. It minimizes cerebral hypoxia and exerts a general tonic effect. The use of nicotinic acid through vasodilatation produces the additive effect with improvement in circulation by improved cerebral oxygen exchange.

Presented at the Michigan Academy of General Practice, November 9, 1960, in Detroit.

Recently hexyacyclonate, a new CNS-alerting agent or anti-depressant type drug, was evaluated by the author,[11] this evaluation being directed towards patients whose apathy was due to cerebral arteriosclerosis, chronic brain syndrome of various etiology, congestive heart failure, and all patients exhibiting varying degrees of decreased or abnormal mental and physical activity. This mode of action seems to be that of a drug having properties of both the monoamine oxydase inhibitors and analeptic drugs. Improvement is rapid—seven to fourteen days—and side effects are very few. It appears to have its greatest utility in the apathetic geriatric patient whose mental and physical activities have been slowed owing to changes in the brain brought on by senility. Improvement was also characterized by increased mental alertness, desire to cooperate with medical and nursing staff members, and strengthened appetite. Improvement was noted in forty-four out of sixty-one patients.[12]

The new anti-depressants in this category (Nardil, Marplan, Tofanil, Niamid, Deaner and Deprol) offer many advantages over the cortical stimulants, such as amphetamine, previously employed in the treatment of depression. These new preparations are long-acting, without depressive rebound, are gradual in onset, non-habit-forming, and do not overstimulate the individual by pushing him above the ideal normal adjustment. These drugs, combined with tranquilizers such as phenothiazine derivatives, are required for agitation secondary to the depression which represents the reaction of the organism to its recognition of the disease.

With the proper application of the balanced activational therapy, it is possible to eliminate electroshock therapy (EST) in 95 per cent of cases. It has been observed that the combined use of EST with a potent anti-depressant drug markedly reduces the amount of EST needed. This program of balanced activation places the patient almost immediately in the normal range of feeling and allows him to resume his responsibilities. Chemotherapy with an anti-depressant and, when needed, a tranquilizer, plays a major role in rehabilitating these patients so that they assume a productive role in the modern society. Recently, nandrolone phenproprionate (Durabolin),[13] a newly developed long-acting steroid, stimulates the synthesis of body proteins. The beneficial effect has been verified both pharmacologically and clinically by nitrogen balance studies.

In a recent survey by myself, an attempt was made to correlate this anabolic effect on senile patients with varying degrees of osteoporosis and osteoarthritis and compare these results with a similar group which had been administered sesame oil. In twenty-one patients ranging in age from sixty to ninety years, 50 mg. were given weekly for a period of twelve weeks. On the Durabolin, seven were improved as against three unimproved; in the sesame oil group, five out of eleven were improved, six unimproved. The mode of action seems to be the prevention of the progress of decalcification. Pain has been alleviated, appetite improved, body weight increased, and bone deformities reduced. Durabolin was not administered to patients with severe cardiorenal diseases or advanced carcinoma, although some patients with an associated carcinoma were given the drug without any harmful side effects. A study by the author[14] on the use of Durabolin is to be published. Whereas young patients have been given these two drugs for other indications—postoperative convalescence, convalescence from pneumonia, fractures, asthenia, et cetera—my results are confined only to the use in this specific age group for combatting osteoporosis, anemia and asthenia due to metabolism. It has also been helpful to convalescence of peptic ulcer patients in conjunction with the original drugs used; that is, anticholinergic and antiacid drugs with the modified Sippy regime. The use of Durabolin in these cases has been most gratifying, particularly in the older age group, in combatting negative nitrogen balance; that is, nitrogen retention. These patients when given 50 mg. of the drug showed improvement, such as gain in weight, appetite promotion, and improved digestion, within a period of three to four weeks.



The Author

BENJAMIN O. MORRISON, M.D.

Summary

The use of the analeptic, anti-depressant, and anabolic drugs, their indications for treatment, their pharmacologic and physiologic action in treatment of the aged, is reviewed. The research of the earlier geriatricians in this field of endeavor, as well as pertinent comments as regards my experience in research, are also noted. The specific indications for use of the analeptics with vitamins, nicotinic acid, and steroids to

overcome central nervous system depression, symptoms of Meniere's snydrome and peripheral arteriosclerosis, and for those drugs which are recommended for each type of arteriosclerosis, is noted. The use and mode of action of the newer anti-depressant drugs—specifically for senile psychoses from cerebral arteriosclerosis, thrombosis, chronic brain syndrome of various ideology—and for those patients with increased or abnormal mental and physical activity, are discussed. Those drugs (sodium hexacyclonate, Marplan, et cetera), in combination with tranquilizers to combat agitation are recommended. These reduce the incidence of the use of electric shock therapy, as well as to promote normal range of feeling and responsibility.

The use of nandrolone phenproprionate, a newly developed, long-acting anabolic steroid to be used specifically to stimulate the synthesis of body protein, is discussed with its mode of action in those severely debilitated, asthenic, aged individuals exhibiting osteoporosis and osteoarthritis, as well as in certain cases of postoperative convalescence, convalescence from infectious disease, fractures, and asthenia.

Conclusions

The practicing physician has at his disposal newer drugs to alleviate patients in the aging process including circulatory disturbances, depressive states of psychosis, anemia, osteoporosis, postoperative convalescence, and convalescence from intercurrent infections. This represents a step forward in the right direction and will give the physician an aid in combatting these diseased states resulting from the deterioration of the arterial system. While these drugs do not effect a cure, they can improve the psychological, mental and physical status of these individuals.

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The Stopped Heart

External cardiac massage, a recently developed technique for restarting hearts which have stopped beating—without opening the chest—is the subject of a new medical teaching film released this week by Smith, Kline & French Laboratories.

The technique, which has been termed "strikingly effective," may well revolutionize the concept of reviving hearts that have failed. In more than 100 cases of cardiac arrest treated by this method at Johns Hopkins Hospital, 62 per cent were successfully resuscitated to their previous cardiac and central nervous system status.

If external cardiac massage, combined with assisted ventilation, is begun within four minutes after cardiac arrest, the central nervous system will receive enough oxygen to prevent serious damage.

The Surgery of Deafness

II. Ossicular Chain Disruption

Brian F. McCabe, M.D.
Ann Arbor, Michigan

SINCE THE resurgence of interest in stapes mobilization procedures for otosclerotic deafness, the extramyringeal tympanotomy has become a commonplace and benign aural operation performed by all aural surgeons. Since the development of this technique, the presence of an unexplained unilateral conductive deafness has come to be accepted as an indication for exploratory tympanotomy. In a significant number of such ears, a disruption of the ossicular chain behind an intact tympanic membrane is found to be the cause of the deafness. Most of these disruptions are amenable to repair by a variety of techniques utilizing autogenous tissue or prosthetic devices, and restoration of binaural stereo-effect hearing to the patient.

This enhanced ability to hear by virtue of two ears is one that is enthusiastically received by the patient, for reasons that we are only recently coming to realize. It was once thought that the only value of the second ear was to enable the subject to localize sound and respond more readily to sounds emanating from his deaf side. Indeed, the American Medical Association legal assessment of the percentage loss of over-all auditory function with one ear totally deaf, is 12.5 per cent. No surgeon who has seen the response of patients to the restoration of binaural hearing can hold this figure valid. It is becoming apparent that where the ears are concerned, one plus one equals more than two.

Causes of Ossicular Chain Disruption

The most common causes of ossicular chain disruption are suppuration, trauma, and developmental malformation. In all cases in this series, the break in continuity has involved either the incus or stapes and never the malleus.

The incus was at fault five times more frequently than the stapes. The long process and, in particular, the lenticular process of this bone was deficient or necrotic in nearly each case of post-suppurative disruption. This is undoubtedly due to the fact that of any portion of any ossicle, the lower third of the incus has the poorest blood supply. Nourishment is derived chiefly through mucosal vessels from above which are endarteries, and through mucosal vessels from the capitulum of the stapes and the stapedius tendon. The exposed position of the long process of the incus traversing the tympanum adds to its vulnerability to suppurative destruction of nourishing mucoperiosteum.

Trauma may disrupt the chain at the incudostapedial or incudomalleal joint, or the stapedial crura. The first is the most common. Basilar skull fractures traversing the fossa incudis may dislodge the incus or immobilize it by bony impingement or fibrous adhesions. The incus may be disarticulated or removed entirely at the time of prior complete ("simple") mastoidectomy. Concussive head blows may disarticulate the chain at either joint or fracture-dislocate the stapedial crura. Manipulative attempts at extraction of a foreign body from the external canal is an occasional cause of disruption.

Congenital deformities commonly involve the ossicular chain behind an intact tympanic membrane, but more commonly behind an atretic canal where a canalplasty is necessary for hearing restoration. The canalplasty portion of the atretic canal operation is so much the more arduous and prominent problem when it is present that it should be considered as a separate topic and not here. When it is present, multiple anomalies of the middle ear are the rule, involving all three ossicles and all three joints. When the canal is patent, the disruption usually involves the proximal half of the chain, namely, the long process of the incus and the stapes. Both structures may be absent or represented merely by a filamentous fibrous remnant. Shortening of the long process may be present with a normal stapes since the latter structure develops independently from the incus. When the stapes is at fault, it is due probably to occlusion of the stapedial artery which courses between the crura from the fifth to the eighth week of intrauterine life. The proper development of the lenticular portion of the long process of the incus is probably dependent upon proper development of the stapes, because no cases

Doctor McCabe is Assistant Professor of Otolaryngology, University of Michigan Medical School.

of faulty stapedial development have been observed without a concomitant faulty lenticular process. Thus, the proper development of a portion of the incus seems dependent upon the stapes, but not the converse.

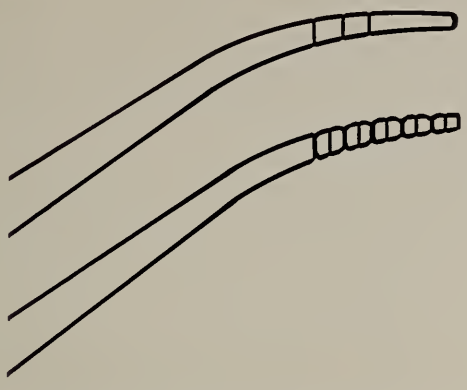


Fig. 1. Two types of measuring rods are useful, one scored at 3, 4, and 5 mm., and another with heavy scores each 1.0 mm. and light scores each 0.5 mm. The scores are visible when sighting down the shaft.

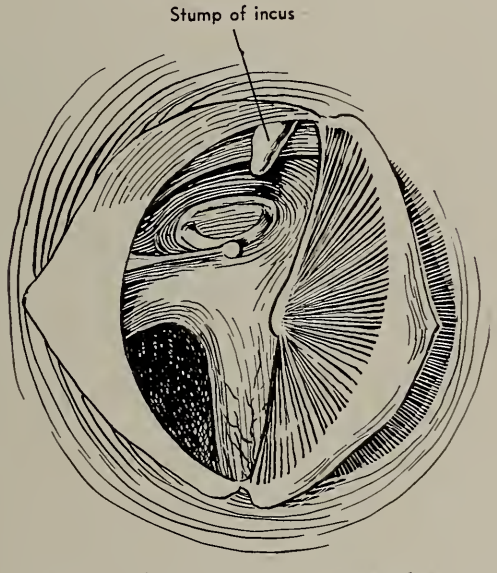
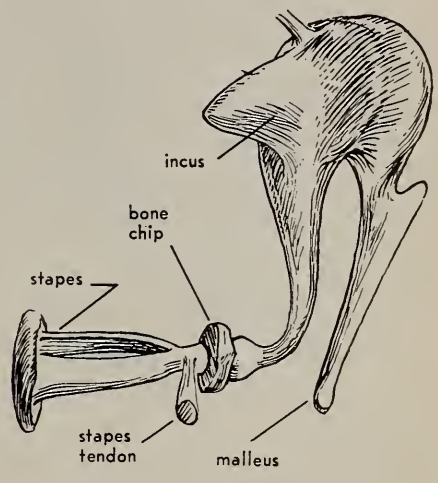


Fig. 2. The tympanum is opened extramyringeally using a V-shaped canal flap, and the exact nature of the lesion noted. Here, the lenticular process of the incus has been eroded by old suppurative disease and the long process is shortened.

Other causes of chain disruption include erosion and pressure necrosis by expanding lesions such as neoplasm and cholesteatoma. When either is present, elimination of this primary disease is of primary importance and not restoration of the disrupted chain. This is a proper subject for tympanoplasty, to be considered in a later article.

Diagnosis

The diagnosis of a disrupted ossicular chain may be suspected in the presence of a normal tympanic membrane and a strongly negative Rinne test (bone conduction stronger than air conduction using a 512 or 1024 cycle tuning fork). The most likely diagnosis at this point is otosclerosis, but when the history indicates a precipitate onset or the lifelong presence of the deafness, otosclerosis may be considered most unlikely. In either event, exploratory tympanotomy is indicated.



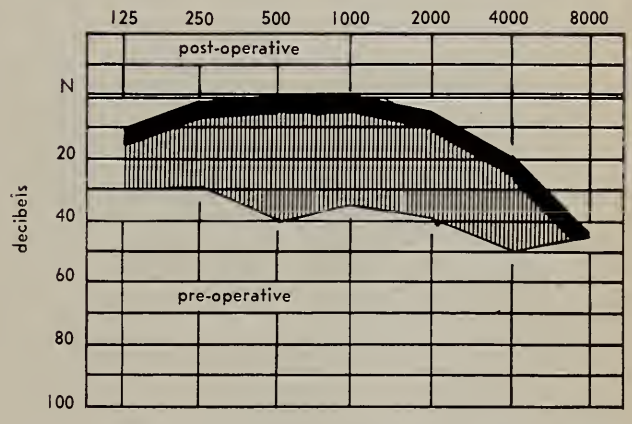
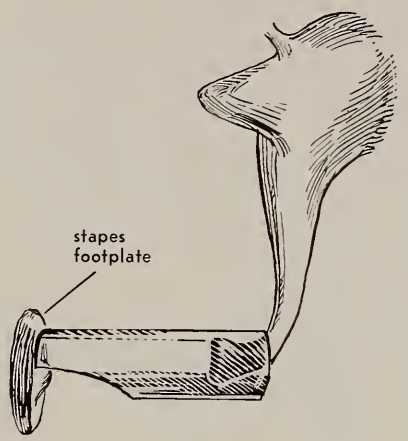


Fig. 3. When the incus is dislocated straight laterally from the stapes, a bone chip may be wedged in place to fill the gap.

It is when the tympanic membrane is abnormal that diagnosis may be difficult and the decision on the course of future action clouded. To a careful history and a meticulous examination, a knowledge of the normal and pathologic physiology of the middle ear conductive mechanism must be added in order to arrive at an intelligent decision. Certain guiding principles are:

1. With the tympanic membrane and ossicles removed, sound may strike the oval and round window membranes at nearly the same time, producing approximately a 45 decibel (db.) loss of hearing.

2. With the typmpanic membrane only restored, this organ now acts as a sound-pressure impeding structure rather than a sound-pressure gathering structure, and hearing is reduced 15 db. further.



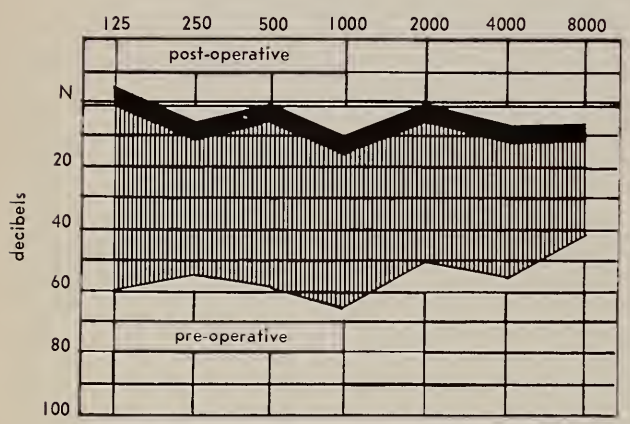


Fig. 4. The stapedial crura are readily replaced by a tapered polyethylene strut or a free bone graft.

3. This impedance quality of the tympanic membrane is variable and the figure 15 db. applies to the normal tympanic membrane only. If large areas of it are thin and atrophic, the impedance may be negligible.

4. If the oval window membrane is unable to respond to sound vibrations, as in otosclerosis, the round window route may assume importance in sound entering the inner ear. The intact tympanic membrane may act as a sound barrier to this new route.

5. With a fixed stapes and only one window available to sound transmission, removal of the tympanic membrane would be expected to provide some improvement in hearing but this would be considerably less than 15 db.

Utilizing the above principles, a distinction between disruption of the ossicular chain and either otosclerosis or chronic adhesive otitis media can be made. In the latter two conditions, the audiogram may be similar because stapedial footplate fixation in otosclerosis and dense scar coating the ossicular chain in adhesive disease decrease hearing by the same mechanism. It is of course impractical to remove the tympanic membrane for diagnosis, but a wide myringotomy for test purposes will do as well. An audiogram is obtained before and after myringotomy, and the shift in hearing determined. This shift is usually diagnostic, but occasionally diagnosis requires tympanotomy and direct examination of the ossicular chain. The findings in each case leading to diagnosis are summarized in Table I.

It may seem academic to some readers to distinguish the three conditions preoperatively since a tympanotomy is usually indicated regardless of which lesion is present. In a sense this is so. But it is advantageous to both the surgeon and the patient to know as closely as possible the chances for success and failure long before entering the operating suite, first, because the relative chances for success or failure may materially alter the patient's decision to undergo a purely elective operation, and second, a patient's thorough understanding of what to expect from his operation is the surgeon's best protection against patient unhappiness and possible suit. For example, the chances for improved hearing are greater in the disrupted ossicular chain operation than in the other

TABLE I. DIFFERENTIAL DIAGNOSIS OF OSSICULAR DISRUPTION VERSUS FIXATION

	History	Appearance of TM	Degree of Deafness	Rise in Hearing Upon Myringotomy	Tympanotomy Findings
Disruption of ossicular chain	Head trauma or deafness from early childhood without progression	Normal to atrophic; healed perforations; less often thickened	Major: 40 to 60 db. loss	Average rise of 10 db. or greater	Visible disarticulation
Otosclerosis	Deafness from young adulthood with slow progression; no otalgia or otorrhea	Normal	Minor to major: 20 to 80 db. loss	Average rise of 5 db. or less	Mobile incus and fixed stapes
Chronic adhesive otitis media	Repeated otorrhea and otalgia	Thick heavily scarred, atrophic patches	Minor: 10 to 30 db. loss	Average rise of 5 db. or less	Fixed incus and stapes

two operations, and the chances for poorer hearing are greater in the otosclerosis operation than in the other two.

Methods of Repair

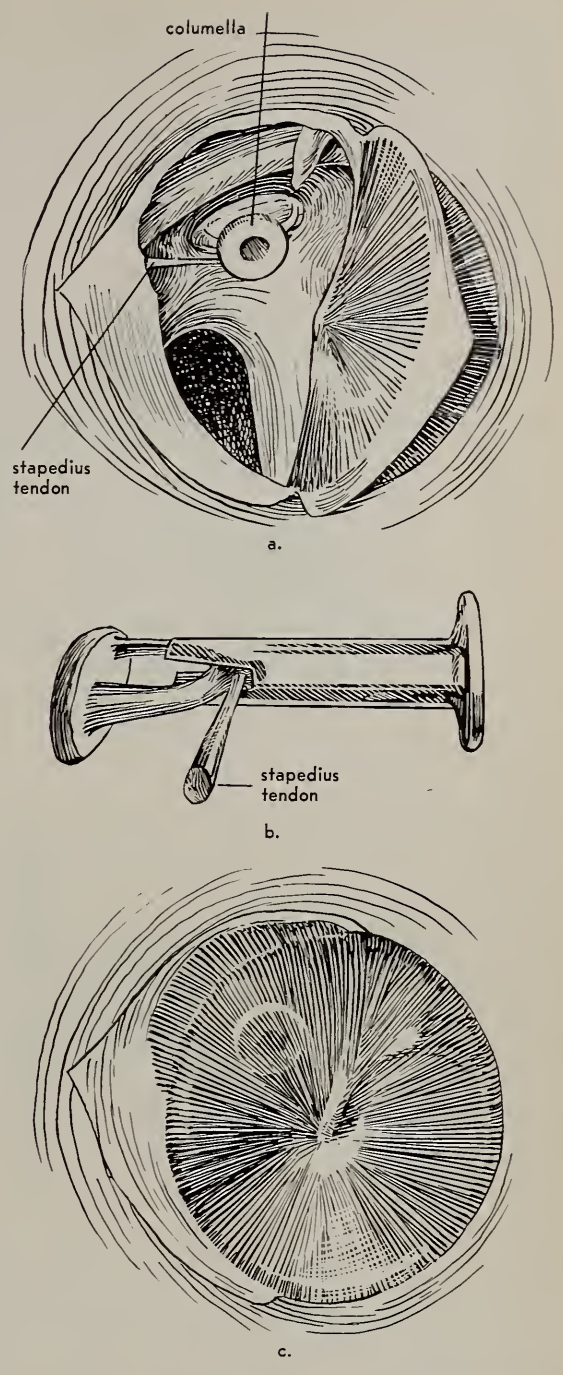
Repair of a disrupted ossicular chain may in each case be performed via the external canal through an extra-myringeal tympanotomy under local anesthetic, and the patient may be discharged from the hospital the following day. The advantages of this approach over modified radical mastoidectomy and myringostapediopexy (where mastoidectomy is not for other reasons indicated) are obvious, besides obviating the mastoidectomy cavity.

The materials used for repair are stainless steel and polyethylene, and those native to the body where feasible. Both the prosthetic materials have been used in the middle ear for five years and in other places in the body for many more, and the literature is singularly lacking in reports of poor tissue tolerance.

The primary principle in effecting a working repair is the interposition of a rigid structure between the oval window membrane and some moving portion of the tympanic membrane. Whether the angle of this structure is a mechanically advantageous one or not seems to make little difference in the final result; normal thresholds are attainable even when a strut approaches 45 degrees to the actuating or actuated surface. When a portion of the ossicular chain is utilizable it may be used, otherwise it is bypassed. Since the lever ratio of 1.5:1 provides a sound pressure advantage amounting to only 2 db., nothing much is lost when it is technically easier to disregard it.

A variety of different situations may be met, and each is dealt with according to the pathological conditions present and established principles of ear physiology. A number of these may be described which cover nearly all the situations that may be encountered, together with a method of repair which has been successful in our hands. Complete closure of the audiometric bone-air gap (conversion of the Rinne from negative to strongly positive) is accounted a success.

Class 1: Stapedial Lesions.—This is the easiest class of disruption to repair. Crural fracture-dislocation may follow a severe head blow. The crura cannot usually be replaced because of shortening of the stape-



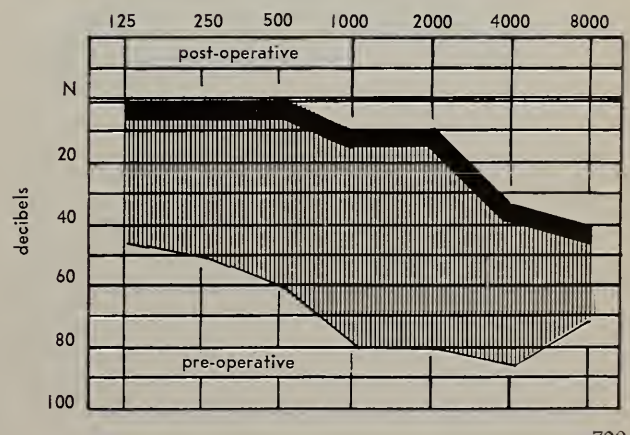
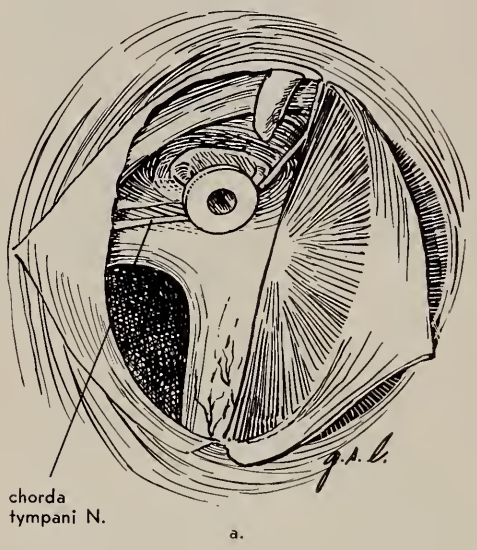
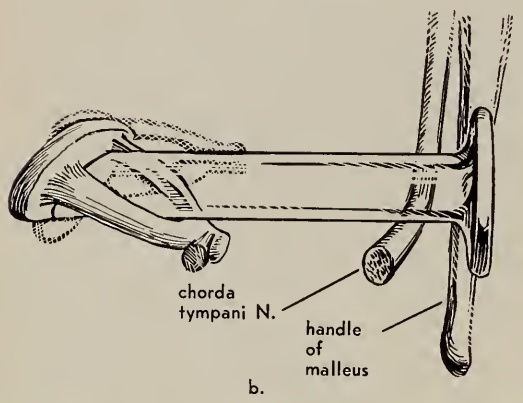


Fig. 5. (a) The posterior bony canal has been cut back to enlarge the circumference of the annulus. A stapes polyethylene columella is in place. (b) A stapes columella straddles the head and also the crura, giving it stability. (c) With the tympanic membrane replaced, the centralizing effect of this on the columella-tympanic membrane point of contact can be appreciated. The membrane is tented out by the strut.

dial tendon. The crura are easily cleared away and a polyethylene tube interposed between the incus and stapedial footplate. The distance to be traversed is first carefully measured, from the face of the lenticular process down, with a special measuring rod. A strut is then cut 0.5 mm. longer than the measured distance and bevelled on the medial end, care being taken to retain a flat surface on the bevelled end. The strut is placed, the extra 0.5 mm. slipping over the lenticular process.





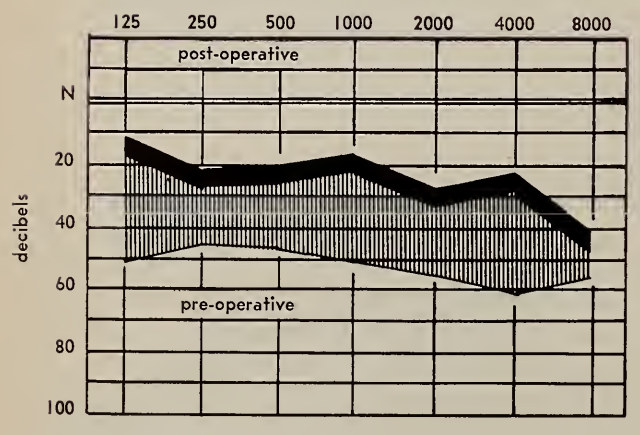


Fig. 6. (a) When the stapes tips too far downward to point a straddling columella toward the tympanic membrane, a footplate columella can gain adequate support by nestling it in the arch of the crura and supporting it in the sling of the chorda tympani nerve. The outer end then abuts the tympanic membrane. (b) The usual, nearly horizontal, position of the stapes is indicated in shadow outline.

A free bone graft has the advantage of obviating the insertion of a foreign body. It is however more difficult to fashion and more difficult to place, the average length of a strut being 4.0 mm. If the stapes fragment has not one crus long enough to span the gap, one may be fashioned from mastoid cortical bone. The proximal end should be tapered and the distal face cupshaped. Fears of resorption of the ends of a free bone graft strut crossing an air-containing cavity are in our experience unfounded.

Class II: Incudal Lesions.—These are of three varieties and comprise the most common class. The incus may be at fault by virtue of being shortened, dislocated, or absent, the result of either trauma, old suppurative disease, or congenital deformity.

The easiest situation to resolve is the dislocated incus displaced straight laterally, with the end of the long process a millimeter or two off the head of the stapes. A bone chip from the annular region tucked into the gap after freshening the opposing surfaces restores the chain.

A long process shortened by virtue of necrosis of the lenticular portion poses a different problem because frequently the bone at the tip is sugary and unable to hold a crimped wire. A solid connection is necessary for normal hearing to be attained. Various ways of meeting this problem have been described, but in our experience two variations answer most exigencies. If the long process is not shortened markedly and the stapediovestibular joint is supple, the stapes may be tipped superiorly and the head held against the long process while the new joint (after opposing surfaces are freshened) is coated with either dental cement or fast-curing epoxy glue. Dental cement will disintegrate after several month's exposure to moisture, but if there is any remaining blood supply in the long process, bony union will have occurred by this time.

Where the long process is shortened, or dislocated anteriorly or posteriorly from normal position, no great attempt need be made to bridge a wide gap because a stapes straddling polyethylene columella inserted as follows can provide normal hearing. Attempts to mobilize and relocate a displaced incus usually meet with failure, the disruption recurring on contraction of the original adhesions.

The stapes-straddling columella is a most utilitarian device for restoration of ossicular continuity. When

this device was first used, closure of the bone-air gap was a rarity. Subsequently, two modifications were introduced which have produced uniformly good results. It was found that the principal cause of a failure was due to a tendency for the outer end of the columella to come to rest against the postero-superior annular rim. This decreased hearing is by two mechanisms: first, through the damping effect of the bony canal wall on columellar vibration, and second, by virtue of the minimal vibrating excursion imparted to the columella with its placement peripherally near the anchored rim of the tympanic membrane. This tendency was circumvented by redesigning the strut so that it straddled not only the capitulum but the stapedial crura thus giving it stability, and by cutting away the postero-superior bony annulus far enough to increase the surface area of the tympanic membrane. The surface area is, in effect, increased by recruiting canal skin in this quadrant, and has the further desirable effect of centralizing the columella on the tympanic membrane by moving the periphery of the tympanic membrane outward. Finally, in order to effect a slight tenting-out of the tympanic membrane, the strut is made 1.5 mm. longer than that measured distance between the head of the stapes and the tympanic membrane. Careful study of a number of successful modified radical mastoidectomies revealed one thing in common: the head of the stapes was clearly visible as it tented out a tympanic membrane draped tightly over it.

In event the stapes cannot be used for a straddling strut, the columella is extended to the footplate, with its outer end cradled in the sling of the chorda tympani nerve and its end against the tympanic membrane. The outer end is flanged wide and flat. The desirable degree of flanging is produced by heating the end of the tube to the melting point near an open flame, then bringing it quickly into contact with a cold metal flat surface. PE90 is the most frequently used size.

Frequently a combined procedure is necessary to rehabilitate the hearing mechanism, such as a sliding flap (viable bipedicle flap) myringoplasty and ossicular chain repair. In order to avoid placement of the outer end of the columella against the inner aspect of the flap, the columella may be notched sharply with very pointed notch tips and placed under the handle of the malleus 2 mm. above the umbo. The relatively high amplitude of vibration near the umbo compensates for the greatly disadvantageous angle at which the strut functions. The inner end should be tapered and wedged against the anterior aspect of the posterior crus at the footplate. If the stapes is intact and the anterior crus lies in the path of the strut, the crura should be sacrificed in 1 mm. above the footplate with a cruratome. Just prior to strut placement, the anterior

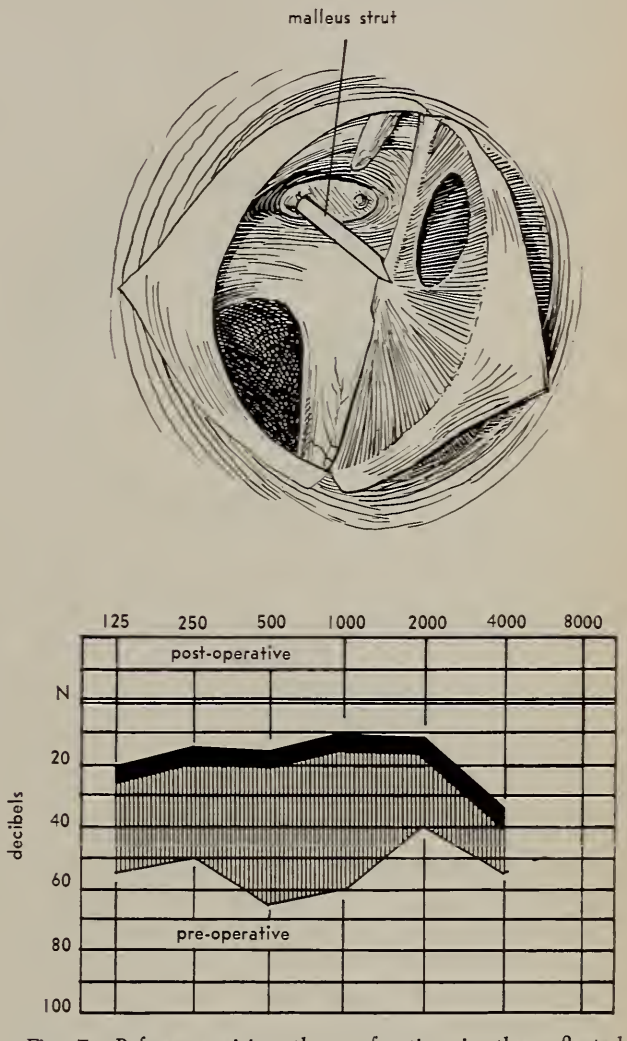


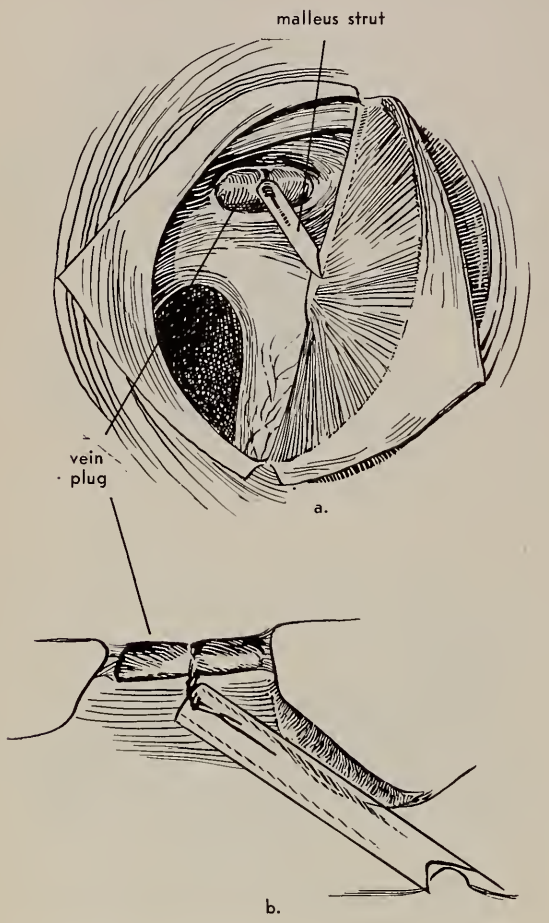
Fig. 7. Before repairing the perforation in the reflected part of the tympanic membrane by the sliding flap technique, the chain is repaired with a polyethylene malleus strut. This strut must be notched deeply at the malleus end, and rested securely against the stump of the posterior crus. If promontorial bone interferes with positioning, it should be cut back as in Figure 8.

slope of the oval window niche should be saucerized or flattened beneath a replaceable mucoperiosteal flap.

Class III: Combined Lesions.—When the incus and stapes are both at fault, the situation may be remedied with either a footplate-tympanic membrane or footplate-malleus columella as described above. The most difficult problems however are those of a faulty incus together with a fixed footplate or malleus, or both.

The more common lesion involves a fixed footplate and an absent incus, as seen in a fenestrated ear with bony or fibrous closure of the fenestra. The first meth-

od of correction tried met with nearly uniform failure. The operation constituted a vein plug stapedioplastic replacement of the footplate with the vein plug wire curved over to and crimped around the handle of the malleus. The reason for failure is obvious. The wire must be malleable enough to allow crimping around the malleus. The slight arch the wire describes in its course out of the oval window niche and toward the malleus is enough to allow vibrational absorption to occur before the impulse arrives at the vein plug in the oval window. The operation is now done in two stages. Vein plug stapedioplasty is first carried out, leaving the wire only 3 mm. above the vein. Three months later, after the vein plug is solidly scarred into place, the wire is sheathed with polyethylene. This sheath is then adjusted to constitute a strut to the malleus, anchored firmly at its medial end by wire.



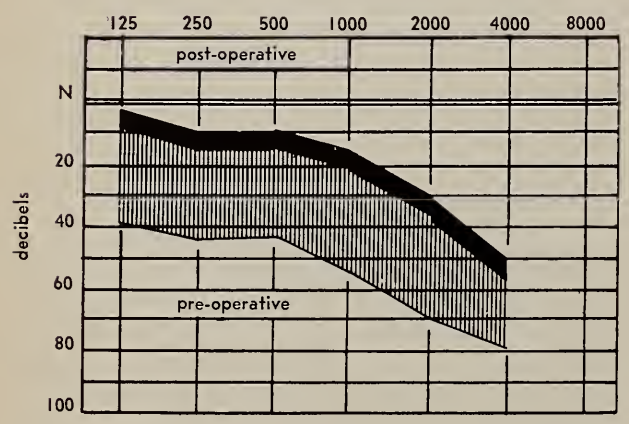


Fig. 8. (a) In the second stage of a fenestration repair, a malleus strut is placed over the wire from the vein plug stapedioplasty inserted at first stage. (b) The wire, scarred firmly in place, anchors the proximal end of the malleus strut. Note the promontorial bone, where it would interfere with free vibration of the strut, has been cut back beneath a replaceable mucoperiosteal flap.

If the malleus is the fixed ossicle, as it is in end stages of chronic adhesive otitis media, the head is the structure fixing it by attic scarring. Before a strut may be applied to it the handle must be rendered mobile. This is done by sawing through the neck of the malleus and inserting silastic film or silver foil between the cut edges, in order to insure the development of a pseudarthrosis here. If the malleus is fixed the incus will be also, and this ossicle should be dissected free or pushed on up into the attic and bypassed. In a second stage, a malleus-footplate strut is placed. If the footplate is also fixed, it may be replaced by a vein plug during the first stage. Where the tympanic membrane itself is severely scarred, thickened, and immobile, surgical intervention is probably contraindicated.

Summary

A significant number of conductive hearing losses are due to a disruption of the continuity of the ossicular chain. The cause of the disruption may be traumatic, developmental, or the result of old suppurative disease. This discontinuity behind an intact tympanic membrane may be determined preoperatively in most cases. It is possible, with a knowledge of how the ear works, to restore the sound conduction mechanism by a variety of measures depending upon the type of disruption.

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Prolonged Labor

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THE PLANNED ATTACK to intelligently and effectively combat prolonged labor must begin in the obstetrician's office with the primigravida's first prenatal visit. This determined effort to materially reduce and, if possible, eliminate prolonged labor must continue with each succeeding pregnancy, whether first or fourteenth. Remember, the state of multiparity does not assure uncomplicated prepartum, delivery and postpartum periods. On the contrary, multiparity may result in complacency of physician or patient, or both, and add to complications. It may actually be a hazard.

How then shall we pursue this problem?

At the outset, we must agree upon what we are attempting to combat. It is essential to realize that not all rhythmic contractions occurring at or near term are labor. Patients, because of contractions, will enter the labor rooms expecting rapid labor and delivery. Examination will reveal long, undilated cervices. They will insist that labor pains have existed for six to eight hours. The Braxton-Hicks contractions of so-called "false labor," have frequently been added to the labor time to statistically and erroneously greatly prolong some labor records.

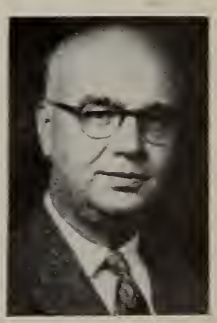
Labor can only be considered present when rhythmic contractions result in progressive effacement and dilatation of the cervix and, ultimately, in delivery of the baby.

Failure to recognize this definition and the possible existence of "false labor" can create complications. An abstracted case from a State Maternal Mortality Survey is presented:

A Gravida IV, Para III, had been in "labor" for eight hours. The cervix was 2 cm. dilated. (This is not an unusual state for a multiparous cervix in a patient not in labor). The physician was dissatisfied with the progress and a sterile vaginal examination was done. (This is a commendable procedure when necessary and intelligently done). During this vaginal examination, the cervix was manually dilated to 5 cm. (Manual dilatation is manual laceration—a mutilating procedure that should never be done). Single-shot injections of increasing amounts of Pitocin were administered until 64 minims were given (enough to propel the infant through the navel). Although contractions increased, the physician was dissatisfied and a second steril vaginal examination was done. This time the cervix was further dilated to completeness, the membranes were ruptured, and a version and extraction done. A stillborn infant was delivered. This was followed by the placenta and profuse hemorrhage. The patient expired.

It is unnecessary to tell you that this extraordinary collection of an accumulation of episodes of faulty judgment and faulty procedures resulted in a fatal ruptured uterus. It is necessary to return to the original point of question. Was this patient in labor when these procedures were started? It is essential that this be answered. Many unnecessary Cesarean sections and traumatic deliveries could be avoided if this question were answered before active intervention.

What is prolonged labor? Opinions vary considerably among all who have discussed this subject. Greenhill[4] designates eighteen hours in the primigravida to indicate prolonged labor. Gainey uses twenty-four hours as the time limit. Calkins[1] varies his time limits with the conditions of the case and indicates the usual instance of prolonged labor to be nineteen hours, with variations up to twenty-four and thirty hours. He indicates that hazard to mother and infant is not usual at twenty-four hours, but is a reality after thirty hours. It is necessary to indicate and emphasize that for some patients, six hours of labor is prolonged. Where faulty prenatal care has been given and marked disproportion or faulty presentation exists, unrecognized, the extent of any labor is a prolonged



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labor. It has been our concept that the primigravida will deliver in between twelve to twenty hours. When questioned by the primigravida concerning what she is to expect, she is told this is the average. The multigravida can be expected to deliver in eight to twelve hours. Labor is considered as prolonged at Milwaukee Hospital after twenty hours. This is considered as the point of action unless clinically indicated earlier.

What is the incidence of prolonged labor? This incidence varies because of various standards. Daro and Gollin[4] of Cook County reported an incidence of 3.9 per cent for labors over eighteen hours. Eastman[4] reported 8.4 per cent with labors over twenty-four hours and 4.9 per cent with labors over thirty hours. Doctor Gainey[3] reports an incidence of 1.42 per cent with labors over twenty-four hours. The statistics of Milwaukee Hospital were reviewed for the year 1959 as a spot check. A total of 2,413 infants were delivered. Of these, thirty (1.24 per cent) had labor over twenty hours, with sixteen (0.66 per cent) over twenty-four hours. There were eight sections. Twenty-six per cent of prolonged labor cases were sectioned as compared to an over-all 5 per cent section rate. Six of these sections were done in patients who were in labor over thirty-one hours. The longest was forty-eight hours. One of the sections was in a breech. Breech was a factor in prolonged labor six times. All of these patients were primigravidas except three. The ages ranged from sixteen to forty-four years.

It is evident that the prolonged labor incidence at Milwaukee Hospital is low and compares with institutions that report incidences as low as 0.5 per cent.

What has been the policy? It should again be emphasized that the attack on the problem of prolonged labor must begin with the prenatal period. Long emphasized for its value in combating toxemia, exacting intelligently conducted prenatal care has a much more inclusive effect on the entire obstetric experience of women.

An essential component of this prenatal care is the combination of an accurate history and the complete physical evaluation of the woman. Knowledge of hereditary tendencies or of existing abnormalities coincidental to the pregnancy may be essential to successful delivery of a living infant and preservation of the mother. The habit of exacting history and physical, fundamental in all branches of medicine, is extremely essential in the gynecologic examination complicated by pregnancy. Continued accurate care and intelligent observation during this important prenatal period will result in detection of conditions which may indicate the possibility of prolonged labor and often preclude vaginal delivery. This observation must include careful evaluation of pelvic capacity, attempted estimation of fetal size, and determination of fetal presentation. Near term, if routine evaluation indicates a failure of the presenting part to engage, or if there is indication of malformation or malposition, it is advisable to obtain an x-ray examination. This will result in determining actual measurements of fetal head as compared to pelvic inlet, midplane and outlet. X-ray should be used where clinical examination indicates the suspicion of midplane contraction. Prolonged labor with its hazards as a result of undetected, undiagnosed midplane contraction will result in far greater damage to an infant than intelligently requested, expertly done x-ray evaluation at or near term. X-ray should be avoided in first and second trimesters. Let us wisely, without hysteria, evaluate and use x-ray—this very valuable adjunct to the successful practice of almost all branches of medicine. But let us remember also that x-ray techniques and interpretations are no better or safer than the man or woman behind the x-ray. All have attended the patient who was doomed to section by x-ray interpretation, only to have her deliver precipitously and most unsuspectedly. All have attended the other patient who, as prognosticated by x-ray, was expected to deliver "in a breeze." This patient would still be laboring if repeated clinical examination and consultation had not pointed to the necessity of Cesarean section.

The detection of obstructing tumors of the birth canal can only be accomplished by instituting routine re-evaluation of the pelvis by carefully done vaginal examinations at the fourth, and seventh month and again near term. This will prevent the catastrophy of surprise and eliminate the torture of suffering through prolonged, dangerous, unproductive labor which can result from an obstructing fibroid or ovarian tumor. Remember, there is no rule which outlaws a carefully done vaginal examination regardless of the period of gestation. However, there are many strong supportive arguments to uphold these examinations.

Additional rewards are recognized for the patient and physician who co-operate in making each prenatal visit an intelligent evaluation of gestation progress and the patient's physical status. The patient must be placed on the table at each visit so that progress of increased fetal size can be noted and the fetal heart can be checked. Careful palpatation by Leopold Maneuvers will reveal errors of position and/or presentation. Additional evaluation of the patient by rectal ex-

aminations will aid in the detection of abnormalities including the problems of the anencephalic infant or the hydrocephalic infant. These detected abnormalities, if known, can be integrated into planning and hazards to mothers and infants greatly reduced by anticipation of complicated labors and use of adequate correct procedures when labor starts. Statistics by Cosgrove[4] indicate that these detectable abnormalities accounted for 57.5 per cent of the causes of prolonged labor in a series from his institution. Other figures vary down to 13 per cent. It is safe to assume that, conservatively estimated, cephalopelvic disproportion and the existence of faulty position is a factor in 20 per cent of the instances of prolonged labor. In the reported series of prolonged labor at Milwaukee Hospital, breech existed six times—an incidence of 20 per cent. Though recognized as a factor position in 3 per cent of all obstetrical cases, breech occupied a prominent place in prolonged labor cases. This incidence of disproportion and faulty position as a factor in prolonged labor can be maintained at a minimum if examinations are intelligently conducted during the prenatal period. Many unproductive prolonged labors which are destined to eventually terminate in Cesarean section or fetal wastage, after prolonged trial and failure, can be avoided by earlier intervention.

Another valuable weapon in the continued fight against the menace of prolonged labor is a proper personal introduction to your patient and an attempt at adequate psychologic conditioning of this patient during the prenatal period. The quality of the seed of confidence planted by the initial impression you make with your patient will grow into her recognition of full security in your care and judgment. A poor impression will create insecurity and can result in a running battle of challenging questions and continuous debate throughout the prenatal period.

Though the physician need not swing on the hysteria of so-called Natural Childbirth, it is essential that he recognize the important contribution made toward relaxation of patient tensions by encouraging expectant mother and parent education. Part of this can be accomplished in the physician's office, part can be done in the many well-organized parent classes[2] which are a part of your hospitals and should be a part of every hospital caring for obstetrical patients. It is the physician's responsibility to direct attention to the many safeguards that have been developed in the past twenty years and the resultant progress made in America in the reduction of maternal mortality to an almost irreducible minimum. In one institution this progress has resulted in a decrease from one death in every 182 deliveries in the period before the 1930's, to one in 11,000 deliveries at present. The reduction of fetal wastage is also rapidly approaching this irreducible status. It is essential that young American mothers are made aware of the persistent drive of the American obstetrical team, led by you, the American physician. Such teamwork has resulted in the fact that America leads all nations: America is the safest place in the world in which to conceive and deliver an infant. With this knowledge, with proper parent education, with the assurance of good health as the result of adequate prenatal examination and care, the expectant mother will advance to the labor and delivery room full of confidence, relaxed to face the contractions of labor and the tremendous experience of labor as a normal process. Such relaxation will reduce requirements for analgesic and amnesiac medication. This reduction of medication removes a source of potential interference with the effectiveness of the labor mechanisms and finally results in a reduction of the incidence of prolonged labor. It is essential that we be instrumental in removing the concept of pain and suffering as associated with the processes of labor. This education can extend even to some churches where altar prayers of Thanksgiving for safe delivery of infants include such conditioning phrases as , "That Thou has protected this mother through the perils and pains of childbirth."

Labor and Delivery

Finally, the moment is at hand. There is a gush of water. There may be a show of blood. There may be evidence of regular contractions. A combination of any two or three may exist. Your patient will not panic. She has been indoctrinated in what to expect. She has the assurance that she is welcome to call you and can contact you or your designated associate, day or night, for assurance and direction. She enters the hospital with reassured confidence and, it is our hope, this will be further increased by the kind and considerate assistance of the registration personnel, and the labor and delivery room staff of nurses and physicians. You, the physician, have the confidence of knowing that many of the problems, of gross deformity and abnormalities, have been detected and eliminated as hazards through your adequate prenatal care and anticipation when labor starts. The result: systematically observed labor can progress.

After it has been established that actual labor exists, you may expect the primigravida to deliver in twelve to twenty hours. You know that from one to 1.5 per

cent of your patients will be in labor over twenty hours. This knowledge should create an alertness which will prepare you for the prolonged case when it occurs. You should be especially alert when attending patients with a dyskinetic labor, where breech exists, when premature rupture of membranes exists—associated with a long, unprepared cervix, or where malpositions exist.

When labor reaches the twenty-hour period, the time which is designated as the warning signal, what is the course? Certainly, this does not mean the patient must be delivered because an arbitrary danger line has been reached. It does mean that *if* delivery is not imminent, the red flare of danger has been ignited, indicating the necessity for a complete patient and progress re-evaluation.

This re-evaluation should be systematic. It should include a review of the patient's labor record up to the time of concern. The intake and output of the patient should be examined and the state of hydration noted. Fluids adequate to establish hydration and nutrition should be given. The character of the contractions must be evaluated. It is well to note that twenty hours of ten-minute contractions are less significant than twenty hours of three-minute contractions. The amount of sedation which has been administered should be determined. A careful sterile vaginal examination should be done to detect problems of position or presentation and definitely establish the degree of dilatation. The character rate and quality of the fetal heart tones must be checked often. If the membranes are intact, an amniotomy may be indicated. Ineffectual labors have converted to productive labors in short order after membranes have been ruptured. No damage can be done if the presenting part is engaged and if the presentation is cephalic. It may be that at this time, clinically, indications point to the necessity of x-ray evaluation.

X-rays should be taken and may reveal the illusive midplane contraction or a straight sacrum, or both. They may disclose malformation or disproportion, or confirm abnormal position. This re-evaluation will be incomplete unless the opinion of another physician, impartial and unrelated to the problem case, is requested. The impact of consultation can be great. The consultation may result in the opinion to further adjust fluid balance, to rest the patient and later stimulate and reactivate labor with intravenous drip Pitocin, or to actively intervene. Consultation may eliminate the hysterical confusion resulting from indecision—indecision resulting from pressure of the patient's family, indecision resulting from pressure due to the physician's own commitments. These pressures or apparent obligations may result in the injudicious use of such procedures as version and extraction which, today, has only limited indications; Durchen's incisions, which can create lasting defects unless accurately made and repaired, and traumatic forceps applications and deliveries. Be aware of the hazards and recognize your responsibilities when Pitocin or Syntocinin are used. Real danger may exist for the primigravida and multigravida (especially old multigravidas) with administration of stimulation, for stimulation may result in rupture of the often traumatized lower uterine segment. The patient's personal response to the stimulation may be such that tetanic contractions will result. This creates great hazard to the infant and can also result in precipitous expulsion of fetus with resultant extensive vaginal, cervical and/or uterine lacerations. It is the physician's responsibility to be available for emergency or have a designated professional representative available to cope with any emergency and to avoid the catastrophe which can result when oxytoxics are administered.

Remember, statistics indicate that after thirty hours there is progressive hazard to both mother and infant. Probably after thirty hours, we are stepping from prolonged labor to neglected labor. If re-evaluation has occurred at twenty hours, and progress has not been satisfactory after rest and hydration, the mode of attack should be Cesarean section. Antibiotics will have been started after twenty hours regardless of ruptured or intact membranes. It is recognized that after twelve hours of active labor, positive cultures can be obtained from the amniotic fluid even when membranes are intact. With intelligent observation and accurate care, the result should be excellent. We point to the fact that in the thirty instances of prolonged labor studied at our institution, which included eight sections, there were no maternal or infant deaths or neonatal problems. There were twenty-two stillbirths and thirty-six neonatal deaths in the 2,413 deliveries. These statistics can be multiplied by many years in our institution and, I am sure, by many institutions throughout the country. The time is at hand that we recognize the necessity of an intelligent approach based on careful evaluation. We must cast aside antiquated methods of obstetrical gymnastic procedures and obstetrical tricks for Cesarean section, when that is indicated. It is time to disregard some arbitrary statistical ceiling which has been set to regulate our judgment when confronted by the decision for Cesarean section. Poor results by section for mother and infant will increase in direct proportion

as length of labor increases beyond thirty hours. This should not mean that we are to set aside caution, policy and indications for what some erroneously consider convenience. Sections still are associated with every hazard of major surgery. If done when indicated, the over-all section rate will not go beyond 5 or 5.5 per cent, and many infants will be salvaged.

The pattern of a patient's future childbearing, indeed the question of whether she will ever conceive again, may depend upon the conduct of her labor and the memory of her delivery experience. Make it a gratifying experience!

Summary and Conclusion

An attempt has been made to indicate the necessity for persistent effort by the obstetrician to combat the entity of prolonged labor. This must start in the prenatal period by complete examination, evaluation and care, and by instilling within the patient confidence in her physician. It continues through the management of labor and delivery, with emphasis directed to the fact that the patient who is informed and has confidence will have a naturally decreased labor time. Although seemingly contradictory, we must admonish that complacency on the part of the physician or patient, or both, because of the tendency to emphasize naturalness, must never be permitted to replace intelligent care by a physician who is well trained to observe, care for, and actively intervene with Cesarean section when necessary—instead of using antiquated obstetrical tricks. It must always be emphasized that the practice of obstetrics is major surgery and that, when least expected, complications may arise which may require surgical skill, or which may result during a fleeting short moment in the elimination of a life because of faulty judgment or the use of a faulty procedure.

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Purified Platelet Cofactor I and Purified Autoprothrombin II in Thromboplastin Generation Test

Purified bovine platelet cofactor I substituted for adsorbed plasma in the thromboplastin generation test when Ac-globulin was also supplied. Only 70 gamma/ml. were needed. Purified bovine autoprothrombin II substituted for serum in the test. Only 9 gamma were equivalent to serum. Platelet cofactor I thus takes the place of the antihemophilic factor and autoprothrombin II substitutes for PTC and Stuart-Prower factor. We regard the autoprothrombin II preparation used as a single component derived from prothrombin. Because platelet cofactor I, platelet cofactor II, Ac-globulin, and platelet factor 3 are not enough to obtain optimal activity, one or more factors are needed in this test. It could be PTA, Hageman factor, or another prothrombin derivative.—Orhan N. Ulutin, Eberhard F. Mammen and Walter H. Seegers, 1961 Symposium on Blood, Wayne State University, College of Medicine, Detroit.

Implementation of the Diagnostic Center Law

A Study of a Rapid Treatment Program

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ACHIEVING a more effective relationship between law and medicine in the management of mentally ill patients has been the goal of the psychiatrist since the late 18th cenutry when Pinel first released the insane from their chains and separated them from the common criminal. Legal intervention has always been deemed necessary—both in order to protect society from acts committed by the sick individual during his illness and, also, in order to protect the individual from neglect and the abuses heaped upon him by society.

With the widespread use of the phenothiazine compounds for tranquilization, the acute or dangerous phase of most psychotic illnesses has been shortened far beyond the period of time required legally to achieve commitment status for the patient. Legal procedures tended to perpetuate abuses of a system of institutionalization which were contrary to the medical welfare of the patient.

With the signing by the Governor of Michigan of Public Act No. 159 on April 16, 1956, the principle of the diagnostic center was established. The law reads in part:

"If it shall appear to the court or jury that there is evidence from the doctors' certificates and from evidence produced in court that such person is mentally diseased, the court shall order such person to be removed to a regional diagnostic center for diagnosis, care and treatment for a period not to exceed 60 days, which period may be extended up to an additional 60 days by special order of the court upon request of the superintendent of the regional diagnostic center."[1]

Similar laws had been passed in the states of Wisconsin and New Jersey; however, they were designed to provide rapid diagnostic services for juveniles.[2]

Act No. 159, as passed, seemed designed mainly to facilitate the psychiatric evaluation and treatment of citizens in the areas of the state where psychiatric hospitals were distant, since private hospitals could be utilized. It also provided the already crowded State hospitals with some hope of respite from additional admissions, provided new facilities could be designated to act as diagnostic centers.

At the Wayne County General Hospital, by using our existing facilities and staff, we broadened our program to include a rapid, intensive treatment program, which utilized the machinery of Act No. 159, to allow time for obtaining limited therapeutic goals. With such a program we hoped to decrease legal red tape and lessen the stigma usually attached to psychiatric hospitalization. Effort was made especially to spare patients the trauma of commitment hearings and the subsequent court proceedings required for restoring the individual's legal status.

Although this hospital served as a diagnostic center from the time the law went into effect in 1957, our accelerated program did not fully get under way until the fall of 1958.

Facilities

The Wayne County General Hospital is located sixteen miles from the center of Detroit. Expansion of the metropolitan area now places it in the southwestern suburbs, comprising a population of more than 300,000. The hospital has three distinct divisions administered by a general superintendent.

1. *The General Hospital Division*, established in 1933, for the treatment of acute medical and surgical patients. It has since become a well known training center for interns and residents in practically every medical specialty.

2. *The Infirmary Division*, for the treatment of the chronically ill, and the care and housing of the ambulatory indigent.

3. *The Psychiatric Division*, for the care and treatment of adult, psychotic patients.

The Psychiatric Division has 2800 patients at the present time. In addition to the care and treatment of these in-patients, the Psychiatric Division administers an out-patient Mental Health Clinic in downtown Detroit for the treatment of psychoneurotic and ambulatory psychotic patients. Furthermore, facilities are

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provided in Detroit for the follow-up of discharged and convalescent leave patients.

The in-patient professional staff consists of twenty-four physicians, thirty-five psychiatric social workers, sixty-seven registered nurses and fourteen practical nurses. Patients are admitted in acute illness from all sections of Wayne County and, by transfer, from the Receiving Hospital in Detroit.

Admission of Patients

Psychiatric patients are admitted upon legal orders issued by authorized persons designated by statute. To facilitate the admission of emergency patients, there are three types of emergency, or temporary, orders:

1. *Forty-eight-Hour Order.*—This is an order issued by police officers upon authorization of the Prosecuting Attorney's office. It is utilized only when an individual is acutely disturbed and is considered dangerous to himself and/or others. This allows for a two-day period of observation to determine if further hospitalization is necessary.

2. *Five-Day Order.*—This is issued by a Justice of the Peace upon receipt by him of statements from two legally qualified physicians certifying that an individual is mentally ill and needs immediate care and treatment. This gives the hospital five days in which to observe the patient and determine what disposition is to be made. Upon proper certification by the Superintendent, this may be extended by the Probate Court for up to three periods of ten days each.

3. *Probate Court Temporary Detention Order.*—Upon petition by a qualified person asking that an individual be adjudged mentally ill, and if accompanied by the statements of two legally qualified physicians certifying that the individual needs immediate care and treatment, the Probate Court issues an order authorizing the detention of the person for a period of up to sixty days. Within the sixty days a hearing is held in the Probate Court, prior to which the person is examined by two Court-appointed physicians. Upon the testimony presented at the hearing by the petitioner and any or all interested persons, and the reports of the appointed physicians, the Court either adjudges the person mentally ill and commits him to a psychiatric facility for continued care and treatment, or finds him not mentally ill and discharges him from the custody of the hospital, or orders a further limited time of hospitalization at a diagnostic center, for which a diagnostic order is issued (see following).

The other, non-emergency, types of orders authorizing the admission of patients are:

1. *Diagnostic Order.*—This is an order issued by the Probate Court, upon proper petition, authorizing a person to be treated in a diagnostic center for a period of up to sixty days, with a possible extension of another sixty days (see page 42, paragraph 4). While it may be issued without a previous order having been entered, it usually follows the expiration of a Probate Court temporary detention order (see No. 3, preceding).

TABLE I

NUMBER OF PATIENTS ADMITTED AND DISCHARGED (1954-1959)

Year	Admissions	Discharges	Per Cent Discharged
1954	856	475	55.5
1955	769	423	55.1
1956	788	519	65.8
1957	946	621	65.6
1958	1149	709	61.7
1959	1811	1108	61.1

2. *Probate Court Commitment Order.*—This is an order issued at a hearing, as explained in No. 3 preceding, if it is determined that an individual needs care and treatment for an indefinite period of time. While this order usually follows upon the expiration of a temporary and/or diagnostic order, it may be the first order issued if an individual has not needed emergency care prior to the date set for the hearing of a petition by the Probate Court.

3. *State Order of Transfer.*—This is an order issued by the State Department of Mental Health involving the transfer of fully committed patients between the State hospitals and/or the Wayne County General Hospital.

By appropriate utilization of the various orders, a patient's treatment may be continued, without commitment, for a period of up to 217 days. When recovered, he has only to receive a certificate of capability from his hospital psychiatrist in order to return to work.

Upon admission, after social case study, psychiatric, medical and psychological examinations, the patient's therapeutic program is outlined with certain disposition goals anticipated. Treatment consists of physiological therapy, drug therapy, and individual and group psychotherapy. Early ground privileges (three to seven days), wearing of personal clothing, retaining valuables, when able, and early participation in recreational and occupational activities are a part of the program for each new patient.

Method of Study

For the purposes of this study, we divided the last six years into three periods and charted the patient movement at this hospital, and the Probate Court activities involved, during those periods:

1. 1954-55, years during which the use of tranquilizers had not yet been established.

2. 1956-58, years during which tranquilizers became established as routine treatment.

3. 1959, the year during which our program of accelerated treatment and quick discharge was in full operation.

Table I shows the number of patients admitted and discharged in the years 1954-59 inclusive.

TABLE I-A. BREAKDOWN OF ADMISSIONS BY SEX
(1954-1959)

Year	Admissions		
	Male	Female	Total
1954	472	384	856
1955	420	349	769
1956	406	382	788
1957	485	461	946
1958	586	563	1149
1959	887	924	1811

Table I-A shows the breakdown of admissions by sex for the years 1954-59 inclusive.

Table I-B shows the ratio of admissions to discharges, by sex, for the years 1954-1959 inclusive.

Table II shows the percentage of patients, rated clinically committable by psychiatrist, who were actually committed 1956-59.

Table III shows the readmission rates for individuals admitted to this hospital for the first time who

TABLE I-B.
RATIO OF ADMISSIONS TO DISCHARGES BY SEX
(1954-1959)

Year	Male		Female		Total Number of Discharges
	Discharges	Per Cent of Admissions	Discharges	Per Cent of Admissions	
1954	273	58.8	202	52.7	475
1955	241	57.4	182	52.1	423
1956	293	72.1	226	67.3	519
1957	348	71.8	273	59.2	621
1958	365	62.3	344	61.1	709
1959	533	60.1	575	62.2	1108

returned following their discharge from the hospital. Ordinarily, a person who has previously been hospitalized in any psychiatric facility in the country is considered a readmission; however, in this study, only those who had had previous treatment at this hospital were considered readmissions. Since percentage change for each year is being compared, the validity is maintained. Data for 1955 were not obtained.

Discussion

There are many factors which influence admission and discharge rates. Wanklin and his associates,[3] in an analysis of first admissions at a Western Ontario Hospital, found a higher rate of urban residents, and more single, divorced or separated people admitted. Also, the rate of admission for the less educated and the foreign born was higher.

Reviewing our results, we found a steady rise in admissions. This trend has been noted throughout the United States (although the resident populations of hospitals have decreased since the advent of the tranquilizing drugs). Cameron[4] attributed the increase in admissions encountered at Scottish Mental Hospitals to:

1. Increased accessibility of the hospitals.

2. The dying out of public dislike of, and suspicion of, such hospitals.

3. The widening of medical and public opinion as to the degree of mental unsoundness which necessitates readmission to a mental hospital.

TABLE II. CLINICALLY COMMITTABLE PATIENTS—ACTUALLY COMMITTED
(1956-1959)

Year	Commitment Potential	Number Committed	Per Cent Committed
1956	769	257	33.4
1957	933	288	30.9
1958	1140	226	19.8
1959	1811	208	11.5

Two other factors played an important part in the increased admission rate at this hospital:

1. The part of Wayne County outside of the City of Detroit which is served by this hospital is growing rapidly. It functions as a receiving hospital for psychiatric emergencies for this growing population.

2. From October 1958 to the present, more patients have been accepted from the Detroit Receiving Hospital than in several preceding years.

The length of time a patient remains in a psychiatric facility, even on a "voluntary" basis, has been found

TABLE III. READMISSION RATES COMPARED WITH FIRST ADMISSIONS
(1954-1959)

Year	New Admissions	Re-admissions	Ratio of Re-admissions to New Admissions (Per Cent)
1954	690	166	24.1
1956	626	162	20.5
1957	770	176	18.6
1958	936	213	18.5
1959	1147	364	20.9

by Storr and Gratnick[5] to be related to the particular function and philosophy of the institution. Orr and Anderson[6] found a short length of stay and a limited education to be significant factors in influencing the discharge of female patients.

We found the percentage of discharges for male patients to be quite similar to the discharge percentage for female patients. A higher discharge rate for females is to be expected due to the woman's ready acceptability in the home, whether she contributes in effort or not.

We agree with MacMillan and his co-workers[7] that, with modern methods of treatment, the patient's stay in the hospital has become shorter. It averages about eighty days for our first admissions. It has also been our finding that keeping the patient in the community, with repeated short-term admissions and discharges on a trial basis as soon as possible, is preferable to a long stay in the hospital, and enables the patient to adjust more quickly and at a higher level. Our experience shows that the accelerated program has resulted in readmissions not significantly higher than those found in 1956 (Table III).

Only in an integrated, community-based mental health service as carried out in Nottingham, England, where more patients are treated in the community by social and out-patient measures, would we expect to see a significant drop in admissions.[7] Possible candidates for admission were seen by a psychiatric team prior to admission in their program. Such programs have been advocated in this country by Blain[8]; however, the community approach is carried on mainly for neurotic individuals and ambulatory psychotic patients at this time.[9,10]

The significant change brought about by this program has been the re-evaluation of commitment as a therapeutic tool. The undesirability of commitment as a part of the therapeutic program was discussed by Gottlieb and Tourney[11] about the same time that legislative measures were being taken to provide more flexibility for psychiatric facilities in the State. They found definite faults in such a procedure and considered it traumatic to patients and relatives.

Our program has resulted in a reduction of commitments by two-thirds in a four-year period (Table II). More significant is the fact that the number of commitments processed in 1959 in the Probate Court for the entire County of Wayne was reduced by 20 per cent. A large percentage of those requiring commitment are brain-injured or have psychoses of the aging. Some of the patients who remained more than 200 days could just as well have been committed and placed on convalescent leave or trial visit. They would, however, have had to petition the court for restoration of legal status. Many employers would not let patients return to work unless they were restored.

We are well aware of the fact much of this change has been due to the use of tranquilizers. There was a 10 per cent increase in discharges when the use of tranquilizers became prominent. This has later leveled off. We find the change in number of commitments has been independent of the improved response to medical therapy.

This program has taxed our facilities and personnel to their limit, but we feel the results have merited the effort. We have demonstrated that similar efforts could not only rapidly reduce the need for construction of additional buildings to house patients but, also, return patients more rapidly to gainful employment. Returning patients to their jobs makes them self-sustaining rather than a continuing financial burden. A small investment now in adequately staffed diagnostic and follow-up treatment centers might produce a greater saving later.

Our experience has emphasized the need for adequate community after-care facilities to prevent the return of patients to the hospital. It is estimated that at least one-third to one-half of the returnees could have been kept out of the hospital by adequate follow-up. MacMillan[7] has found that such community facilities reduce admissions by almost 50 per cent; we are of the opinion that such facilities could do the same to reduce readmissions.

Conclusions

1. The Regional Diagnostic Center Law has been adapted to promote an accelerated, intensive treatment program.
2. Although admissions and discharges have risen, the ratio of returns to this hospital has shown no significant increase.
3. The discharge and re-employment of male patients has been facilitated by rapid treatment without commitment.
4. Commitment of patients admitted to this hospital has been reduced to one out of every ten admissions.
5. This accelerated program has resulted in a 20 per cent reduction in commitments in Wayne County.

Summary

The use of Public Act No. 159, the Regional Diagnostic Center Law, as a tool in the formation of an acute intensive treatment program has been studied. The effect on patient treatment, rehabilitation and commitments has been evaluated.

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Cataract and Glaucoma

An estimated million persons in the United States have a serious eye ailment—glaucoma—without knowing it, and thousands become blind unnecessarily from the ailment every year.

Even more people become blind from cataract, a better known but often neglected, eye ailment. This is also largely preventable.

These facts are underscored in a pamphlet entitled "Cataract and Glaucoma—Hope Through Research" which has just been published by the Public Health Service.

The pamphlet describes these two principal causes of blindness and how the ailments may be arrested or prevented. Research at the National Institute of Neurological Diseases and Blindness at Bethesda, Maryland, and in other medical centers in the United States and abroad is described.

Cataract and glaucoma are separate ailments, the pamphlet points out, and each can be treated by an ophthalmologist. Laymen should not attempt self-diagnosis or self-treatment, the pamphlet warns.

In advanced cataract, the whitened lens can be seen where the black pupil or opening in the colored iris normally appears. Usually an eye surgeon can remove the chalky lens and restore both reading and distance vision.

In glaucoma, internal eye pressure increases and threatens to strangle the optic nerve and the blood vessels that nourish it. A block in normal eye drainage is the usual cause of such increased pressure.

The pamphlet points out that only by measurement of eye pressure with an instrument called a tonometer can increased pressure be discovered by a physician before symptoms are noticed. A person usually does not become aware of the ailment until vision loss has begun. Even at this point, glaucoma treatment with medicine or surgery usually can control eye pressure and prevent further loss of eyesight.

"Cataract and Glaucoma—Hope Through Research" is listed as Public Health Service Publication No. 793 and Health Information Series No. 99.

Single copies may be obtained without charge from the Public Health Service. Orders under 100 are 15 cents a copy from the Superintendent of Documents, Government Printing Office, Washington 25, D. C. There is a 25 per cent discount on orders of 100 or more going to one address.

Calcium Chloride Necrosis of the Skin

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A PROBABLE public health hazard in suburbia was brought to our attention by the observation and treatment of the following case.

R.H., a white boy of four and one-half years, when undressed at bedtime by his mother had a painless black patch on the anterior surface of the left thigh. In attempting to determine the cause, Mrs. H. examined the boy's clothing and found the left pocket of his blue jeans wet and discolored. In this pocket, she found a wet paper handkerchief and wet slag. The boy, with his friends, played in or near a slag road recently treated with calcium chloride flakes to reduce the dust. The mother had helped him dress at about 11:00 a.m., using a clean and recently laundered pair of blue jeans and cotton underclothes. The boy was undressed at about 10:30 p.m. The mother was unaware of a previous injury or abrasion of the skin in the involved area.

When the boy was observed at the office (S.C.S.) the next day, the area of dry gangrene was more than 2.5 cm. in diameter on the anterior surface of the left thigh adjacent to the area where the pocket came in contact with the skin. Thirty-two days later, with separation at the edges, most of the necrotic area was excised. After excision, a greenish-grey base with several aggregations of brownish-black punctae was noted. The necrosis obviously extended into the subcutaneous fat. Six days later all of the necrotic tissue had sloughed out. Healing occurred by secondary intention.

Histopathological examination (H. Pinkus, M.D.) of a portion of the necrotic slough revealed mummification or complete necrosis of the epidermis, the entire corium, and even some subcutaneous fat tissue. At the lowest part of the specimen, there was a small amount of living tissue with some reactive inflammatory infiltrate. Hematoxylin and eosin sections stained somewhat bluish. Van Kossa stains were positive. There were definite deposits of silver granules in somewhat spotty fashion on collagen and elastic fibers, not much on the epidermis.

A portion of the excised necrotic tissue was submitted for microincineration. Of this, 587 mg. of dry tissue was ashed and yielded 16.5 mg. of total ash. Of this 5.48 mg. or approximately 33 per cent of the tissue was calcium. Microincineration of three control specimens of skin obtained from post-mortem specimens at Children's Hospital revealed 0.93 per cent calcium in one, 1.02 per cent in another, and 1.96 per cent in the third specimen.

From the Department of Dermatology (Dr. I. Botvinick) and Department of Industrial Medicine and Hygiene (Dr. R. G. Smith), Wayne State University College of Medicine.

Our case was comparable with the case of Nash.[1] His patient, a twenty-nine-year-old Turkish laborer, developed thick black eschars surrounded by a thin border of inflammation within twenty-four hours after



Fig. 1. Area of necrosis approximately two weeks after exposure.

he splashed his trousers with a 40 per cent solution of calcium chloride he was making up for use as an anti-freeze. The ulcers were preceded by pain and occurred where the tops of his gum boots had rubbed.

We could not obtain a reliable history of pain preceding the onset of the necrosis nor could we obtain a history of preceding trauma. It is possible that penetration of the skin by the calcium chloride was aided by the presence of another compound on the slag. We have been unable to solve this problem.

Oppenheim's patient[2] developed papules and small nodules at the area of contact with a concentrated calcium chloride solution. Heppleston[3] described ulcers and non-ulcerated papules in a worker due to contact with 40 per cent calcium chloride solution used as a dust laying spray in a coal mine. Edmonds[4] re-

ported punched out ulcers of the knuckles, follicular excoriated dermatitis with erythema on the flexor surfaces of the wrists and neck and excoriated dermatitis of the front of the ankles and shins in coal miners exposed to mine water with 51,900 PPM $CaCl_2$, 10,200 PPM $MgCl_2$, and 129,500 PPM NaCl. Zackheim and Pinkus[5] described two cases of necrosis of the superficial corium due to surface contact with dry calcium chloride. Snedden and Archibald[6] described calcification of the skin in coal miners due to contact with roof water of a coal mine which contained 3.5 per cent calcium chloride, 0.5 per cent magnesium chloride and 10 per cent sodium chloride. An apparent Koebner phenomenon was observed. They reproduced the lesion experimentally by applying a similar solution to the scarified skin.

Summary

Necrosis of the skin of the thigh on a boy of four and one-half years due to exposure to calcium chloride used in controlling dust on a slag road is presented. A history of previous injury of the skin could not be obtained.

Acknowledgment

Control specimens were obtained through the cooperation of Dr. Jay Bernstein of the Children's Hospital of Michigan.

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Drinking Drivers

A health specialist at the University of Michigan urges a "get tough" policy to counteract the flood of traffic deaths and injuries caused by drinking drivers.

Seward E. Miller, M.D., says, "We can begin by finding a better word than 'accident.' An 'accident' implies the event is out of the hands of the driver. But drunk driving is entirely the personal responsibility of the driver, and he should be held firmly accountable for his acts."

In the May-June issue of "Police" magazine Dr. Miller recommends four steps in cracking down on drinking drivers: He proposes a strong campaign to declare drunken driving a serious crime against the public safety, correction of laws so that drunken driving be judged on the basis of modern scientific knowledge, adoption of new laws to provide severe penalties for drunken driving, and rigid enforcement and staunch public support of the police agencies and an end to popular molly-coddling of drunks.

Dr. Miller points out that present laws consider an individual "under the influence" only when his blood alcohol test is above 0.15. Modern scientific knowledge shows driving ability is impaired at about 0.04 per cent alcohol in the blood. "In about 50 per cent of fatal auto accidents a drinking driver is involved. If we had such clearcut evidence about the cause of cancer, there would be a booming public outcry to put an end to it."

Public Health---Present and Future

Malcolm H. Merrill, M.D., M.P.H.
Berkeley, California

SOME YEARS AGO, I chanced upon a magazine article entitled "No Age is Golden." It pointed out that each generation throughout history had considered its problems as new, unique, and more critical than any that had gone before. Yet, with passage of time, posterity tends to look back upon the "good old days" as having been more desirable than their own period, and they even think of some of these earlier troubled eras as "golden ages."

Surrounding us today are alarmists who once again would have us believe that our times are the most critical in all of history. I happen to be of an optimistic turn of mind. This doesn't keep me from recognizing that we have many and important issues which demand solution, and it reminds me that we have more resources for facing these issues than man has possessed at any other time in history.

Political and social organizations are better organized to attack international problems than ever before in history. The United Nations Organization has repeatedly demonstrated its effectiveness in the solution of critical problems. This is a new instrumentality, a new resource that our generation possesses. In our field of health, the World Health Organization, an agency of the United Nations, is a rallying point for a world-wide attack on disease and disability.

Going hand in hand with these official governmental agencies is an expanding international voluntary association effort. The emergence of a World Medical Association and a whole series of international specialty groups, with associated congresses and conferences for the exchange of scientific information, are all making significant contributions to the solution of problems in the field of health. And along with these organizational resources we have the greatest fund of scientific knowledge and scientific competence to apply this knowledge that man has ever possessed.

These generalities are mentioned as a prelude to consideration of some more specific matters in the health field about which physicians are now concerned and will be increasingly concerned in the future.

Truly, we are living in a changing world. It has always been changing, but the rate of change is greater than ever before. Just as these changes are influencing every other phase of life, they are also influencing medicine and public expectation of health services.

Here, I shall try to sketch some of these trends and the changes that are having or may be expected to have an influence upon the health of the people of our country; and what is being done and what we should consider doing about them. I shall not attempt to relate these changes to the world-wide picture.

Let us begin by considering some of the social and environmental changes that we who have an interest in health must take into consideration in planning for the future.

Population To Be Served

Since, as physicians, we are concerned with people, one of our basic considerations must be how many and what kind of people are to be served.

The 1960 census records 180 million people in the United States. This is estimated to increase to 235 million by 1975, an increase of some 55 million. The greatest increase will occur at the two ends of the age spectrum; the under-twenty-one will comprise 114 million, as compared with 65 million in 1955. This group will comprise 40 per cent of the total population as contrasted with 29 per cent in 1955.

The number of people sixty-five years and older is estimated to expand from 15 million in 1955 to roughly 21 million in 1975. It should be particularly

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Presented at the Annual Session of the Michigan State Medical Society, Detroit, Michigan, September, 1960.

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noted that, while the number will increase by over one-third, the actual per cent increase in terms of the total population is less than 1 per cent—contrasted with the 11 per cent increase in the under 21 age group. This fact is frequently not considered by the alarmists. Our nation is actually getting younger faster than it is getting older.

The average life expectancy is slowly increasing. At birth it stood at 59.7 in 1930, 62.9 in 1940, 68.2 in 1950, and close to 69 in 1960.

Unless there are very significant break-throughs in the fields of major causes of death, we can hardly expect in the next decade any remarkable changes in average life expectancy.

Life expectancy at the age of sixty has undergone surprisingly little change since the turn of the century. The average remaining lifetime at age sixty for white males has increased only one and one-half years, and for white females, only about four years since 1900.

The implications of these population changes are far-reaching. The greatest increase in the demand for medical services will be in the fields of obstetrics, pediatrics, and geriatrics. In terms of percentage distribution by category of all medical services, there will be a relative percentage increase in these three areas.

What are the implications in terms of medical and paramedical manpower needs? In order to maintain the present physician-population ratio of 140 per 100,000 population, it will require 330,000 physicians by 1975. This will necessitate the annual graduation of 11,000 medical students—an increase of approximately 3,600 over the number of 1959 graduates. This will require thirty-six new medical schools, each graduating 100 students a year.

The figures for physicians are used here simply as an illustration, because the situation is the same with respect to dentists, nurses, and all paramedical personnel.

It is the impact of such estimates as these that is causing so much interest on the part of federal agencies, the Congress, and many state governments in meeting the medical manpower needs of the future.

The implications from the standpoint of medical facilities are equally impressive. Using the present estimates of 10.5 beds per 1,000 population as hospital requirements, there will need to be added more than 300,000 hospital beds in the country by 1975, and at a cost of over nine billion dollars. This is without reference to modernization and replacement of obsolescent facilities.

In the broad areas of providing manpower and facilities to meet the health needs of the people of America, medical statesmanship is needed to team with government and voluntary effort to solve the problem. There are encouraging signs that this will be done. In my own state of California, during the past year an extensive study under the aegis of the Governor has been entered into vigorously by medical, hospital, and other associations in co-operation with the state government to define the respective problems and to delineate approaches to their solution. The same has been happening in New York and in other states.

At the federal level, extensive studies have been undertaken to define the problem nationally and to determine the role of the federal government in its solution.

Changing Patterns of Morbidity and Mortality

All the above considerations are primarily related to the number and age distribution of the population. Let us now turn to a second general consideration—the changing patterns of cause of morbidity and mortality. The great plagues of history are no longer with us in this country. The major communicable diseases play a relatively minor role now as direct causes of mortality. Smallpox is a rarity; diphtheria, while still much more frequent than is necessary, is of minor significance as a cause of death; typhoid fever is an infrequent occurrence; tuberculosis no longer appears among the ten leading causes of death; syphilis and its multifarious complications is within reach of eradication; malaria is essentially controlled. With these diseases, the major problems of the future will be the maintenance of control. These and many other accomplishments are monuments to medical and sanitary science.

Nevertheless, even the communicable and infectious diseases are far from controlled. There is a vast array of viral diseases yet to be conquered. The respiratory virus diseases alone represent perhaps the most frequent current cause of morbidity and the most frequent cause of loss of work time. Encouraging beginnings are being made in the way of more clearly defining the etiology of the virus diseases and in approaching prevention through specific prophylaxis. With the diminishing incidence of poliomyelitis there is being revealed a whole constellation of enteric viruses that are actually or potentially pathogenic.

Antibiotic-resistant bacterial infections occurring in hospitals and the community are rising to plague us.

All of this means that to maintain our gains and

push forward to further accomplishment, eternal vigilance, and intensive and extensive research will continue to be necessary in the field of communicable and infectious disease control.

With the diminishing over-all importance of communicable diseases, however, it is the chronic diseases —cardiovascular disease, cancer, diabetes, arthritis, asthma, and a host of others—that are looming ever larger as our health problems. Associated with these is the rising importance of accidents as a major cause of death and disability. Accidents now stand in first place as cause of death between the ages of one and thirty. For every death there are at least twenty injuries severe enough to cause hospitalization.

Concomitant with these changes in the morbidity and mortality picture is a significant shift in emphasis in medical practice. Pediatrics is increasingly a health maintenance and disease prevention practice. Obstetrics is increasingly so, too. In fact, every physician is, to an ever increasing degree, practicing preventive as well as curative medicine. Early detection of disease and active therapy while still in the asymptomatic stage is gaining as a routine part of medical practice.

A still further significant trend is the increasing emphasis being given to rehabilitation. Physicians are now and will in the future to an increasing degree be concerned with the total rehabilitation of the patient, including emotional, social, and occupational as well as physical rehabilitation. The team approach involving physician, nurse, social worker, psychologist, homemaker, and other disciplines is gaining in importance. Chronic disease hospitals and nursing homes are changing from places for custodial care to centers for active therapy designed to effect maximum rehabilitation. Rehabilitation centers, either as such or in association with general hospitals, are becoming an important facet of the total medical resources of the community. Since this area of medical care is so intimately related to community resources and services, it would seem inevitable that health departments will become increasingly involved as a member of the team.

Implications of Environmental Changes

May we turn now to a third general area of changes which have health implications. These are the extensive changes in the physical environment. The chemical, technological, jet, and atomic age has brought many new threats to health as well as actual and potential resources for the promotion of improved health.

Chemicals.—Chemicals are becoming increasingly important as a health hazard in the physical environment. Between 400 and 500 entirely new chemicals are being put into use each year, and new waste by-products incident to their manufacture and use must be disposed of. These new chemicals include plastics, food and fuel additives, pesticides, detergents, and abrasives.

All the chemicals in use are checked for toxicity, but the long-term potential hazards of many of them, their possible cumulative and synergistic effects, are still largely unknown. Increasingly, toxic chemicals can reach the people through air, food, and water.

Air Pollution.—Air pollution is another increasingly important health hazard of the physical environment. The air we breathe is becoming a limited resource, something never dreamed possible a few years ago. Pollution is increasing from chemicals, smoke, dusts, and radioactive fallout. The simultaneous presence in the air of various chemical substances can multiply the toxic effects of some. California-type smog is produced by reactions taking place in the air between very low concentrations of hydrocarbons and nitrogen oxides with atmospheric oxygen in the presence of sunlight. The simultaneous presence in the air of these substances, which individually in low concentrations are apparently harmless, produces oxidants that are irritating to the eyes and mucous membranes and damage or destroy certain plants. The full extent of the effects of air pollution on health is not known. Chronic bronchitis is increasing in some areas and there is increasing evidence that the rate of occurrence is related to air pollution. Evidence is mounting that lung cancer and emphysema may be related to air pollution. Extensive studies in this field in the years ahead will be necessary, and intensification of control and preventive measures is imperative.

Water Pollution.—With the tremendous population growth and concentration in cities, demands on the limited water supplies are creating health hazards. Water needs are expected to double in the coming decade. Heavier demands are placed on sewage treatment facilities and water purification plants. Already in the flow of a river to the sea, its water may be used and re-used many times. Water resource planning, storage, impoundment, treatment, and control of chemical content take high priority today. Man's struggle to keep ahead of his wastes is becoming more difficult now that there is not only sewage and

garbage to dispose of, but increasingly complex radioactive and chemical wastes in huge quantities. Disposal of radioactive wastes is a particularly difficult and urgent problem, and a sensitive one, too.

Radiation.—The growing use of nuclear energy, with the attendant increase of radiation in the physical environment, forces the health hazards of radiation to our attention. Even if the dangers of radiation from atomic and hydrogen bomb fallout are ignored, the increasing use of nuclear energy in industry, the use of radio-isotopes, the much more widespread use of radiation in medical diagnosis, and the increased number of other sources of radiation present serious potential public health problems that are here now and will increase during the years ahead. Physicians have a long experience in the successful beneficial use of x-ray, and this will be invaluable in helping to establish standards for wider use of radiation.

The great benefits of x-ray as a diagnostic procedure have brought about a tremendous increase in its use over the years and in its availability to ever larger segments of our population. As a result, medical uses of radiation contribute 50 per cent or more of the present radiation dose of the entire population, as compared with 1 per cent or less from radioactive fallout or wastes. At present, medical uses contribute a dose equal to, or slightly larger than, the dose from natural background sources.

Man has always lived with natural radiation, and this source is fairly constant. We cannot do anything to lessen the natural background radiation, but the obvious place to reduce radiation exposure without changing our way of living is to decrease the dose from medical use.

The wide experience of physicians with x-ray has already enabled the medical profession to develop and establish standards for reducing the dose of radiation to patients without interfering with its diagnostic value. Competent authorities in the field of medical radiation have stated that the dose to the patient population of this country can be decreased to 10 or 20 per cent of the present level without in any way limiting any necessary examinations.

These standards that have been set pertain to safe and efficient equipment, skilled technique, and careful consideration of the clinical indication for the use of x-ray procedure. If the medical profession can bring about even a slight decrease in the radiation dose from medical procedures, this can completely offset the dose the population now receives from radioactive fallout, nuclear industry, and radioactive waste disposal. As physicians we have a serious responsibility here.

It is urgent that much more be learned about the long term effects of low-level radiation and, in the meantime, we must keep the radiation dose from man-made sources as low as is practicable and desirable. Control measures will need to be extended. The last session of the California Legislature took a step in this direction by passing laws which establish a mechanism for co-ordinating state control programs and which require every source of radiation in the state to be registered with the State Department of Public Health, including medical, dental, industrial, and scientific sources. Most states have either adopted or have under consideration comparable laws.

But in the concern over the possible health hazards of radiation, sight should not be lost of the tremendous potential benefits for health and welfare presented by this newly discovered source of energy.

Other Physical Factors.—Temperature, pressure, sound, light, and speed are other factors of the physical environment that have pronounced effect on health, particularly occupational health. Many workers today are subject to extremes of these factors to the detriment of their health. The partial deafening of men who work around the roar of jet planes is one example. Every large airport now brings public attention to the problem of the effect on people of noise from jet planes.

Social Environment.—In medicine it is being realized, perhaps more than ever before, that changes in the social environment also have health implications. A mere listing of some of the changes in the social environment that are recognized now and that may be expected to continue, suggest that some of these will be favorable to health, while others will intensify physical and biological hazards to health, or create social health hazards.

A mere listing of a few of these changes will serve to indicate the health implications:

Increasing urbanization and the creation of great metropolitan complexes with three-fourths or more of Americans living in metropolitan areas; increasing mobility of the population, both geographically and socially; changing patterns of living; an increasing number and proportion of older people in the population with all the problems this presents; speed of transportation and increased tempo of living with resulting increased stress and tension; higher living standards; shorter work periods; increased leisure time; more recreation opportunities; better nutrition; and better housing.

The protection of the nutritive value and of the safety of the food supply may be cited as one example of the health implications of these changes. Food sanitation, refrigeration, and pasteurization of milk have been great advances in health protection, but modern methods of growing and processing foods have brought new hazards from preservatives and other food additives, contaminants related to packaging, and residuals from agricultural chemicals. The "cranberry scare" is still vivid in our memories as an example of chemical residues in food. Since then, amendments to state and federal pure food laws have been passed to further safeguard public health. But here, as with radiation, the present and potential benefits of the many new chemicals must not be ignored. Their use has not only helped to keep under control many diseases carried by insect and rodent vectors, but has already increased the food supply many times over. Agricultural chemicals have been an important factor in keeping the food supply in this country far ahead of the demands incident to the tremendous population growth.

Famine and actual starvation are almost unknown in this part of the world, and nutrition has been greatly improved; but, ironically, obesity is now a health problem.

Today's complex social structure compounds the hazards to emotional health. *Mental illness* in its various manifestations becomes increasingly the concern of physicians and public health.

Almost one-half of the hospital facilities of our country are devoted to the care of the mentally ill. These, for the most part, are large isolated institutions. More and more mental patients in the future will receive care near home in community general hospitals. There is a remarkable upsurge of attention being given to this important problem. Intensification of therapeutic measures applied to the mentally ill with broad spectrum approach to rehabilitation, expanding research endeavours, and sharpened attention to preventive measures will characterize the attack on this extensive problem in the coming years. Already community mental health programs are being developed in many areas of the country under medical leadership. As with rehabilitation in general, broad community resources will increasingly be applied in this area. More attention will be given to assisting the patient in readjusting to normal living and to home care services.

Inadequate housing and *economic stress* create social as well as physical health problems. Crowding into cities has magnified these problems. Attempts to better the housing situation by slum clearance has brought its own emotional problems through separation from friends and neighbors, disruption of community services and facilities, and economic burdens from higher rents.

The health implications of migration must be considered. The agricultural migrant laborers and all their associated social and health problems come within the purview of the planning for health.

While the social environment creates many health problems and aggravates others, it must be borne in mind that it also provides the means of solution, through favorably influencing human behavior.

In public health and medicine it will be necessary to become more seriously concerned with planned change, induced change, in people's behavior. The success of public health and increasingly of all medical programs depends to a great extent on persuading a majority of people in a given area to co-operate in health measures, to change certain habits, to give up old practices, to adopt new ones.

Understanding of human behavior will have to be recognized as basic to effective public health and medical programs. It will be necessary to promote social science research related to health, and to learn to apply the results in public health work.

Economics of Health Services

Problems surrounding the economics of health services is a fourth general area of change that is occupying much of the time and attention of the medical profession and increasingly of legislative bodies and many segments of the populace at large. The age of prepaid medical services is here and will inevitably play an increasing part in the economics of medical services. The central issue being debated at the present time, and which will probably be decided during the coming decade, is the role that government is to play in this area.

Medical Research

A fifth area of change in which medicine has a great interest is the emphasis being given to medical research. It is estimated that in 1947, 88 million dollars was expended in this country on medical research and development. This had increased to 330 million in 1957, probably exceeded 500 million in 1960, and further expansion appears most probable. An increasing proportion of medical manpower will be devoted to such research and development. How to

apply this increasing fund of new medical and scientific knowledge in an economical and productive way will itself present significant problems.

Consumers of Medical Services

A final area of change which I should like to mention pertains to the consumers of medical services. The public knowledge of medicine is increasing; the mysteries are being swept away. With this has come increasing expectation of what the wonders of medicine can do. It appears the public has placed a sufficiently high priority on medicine that there is a willingness to expend a relatively greater proportion of the gross national income for health services. This public sentiment should be taken into consideration in planning for the future.

Summary

This brief sketch is one public health administrator's attempt to delineate some of the major areas that will be of concern to medicine and public health in the years ahead. Since public health is the specialty in medicine that represents physicians in the health field in government, it is imperative that there be a firm and effective co-operative relationship between the specialty of public health and the rest of the medical profession. The age of planning for the future is here. We, in the medical profession should be as one in the forefront of this planning. We must work together in planning for the needed health manpower, for needed health facilities, for stimulation and planning of research; in planning for the application of scientific knowledge as fast as it becomes available, in planning for the protection of the physical and social environment so the people of America will have a healthful place in which to live, and in planning the mechanism by which all of these services may be financed on a sound and economical basis.

Phenylketonuria

In Michigan, four infants, genetically destined to be mentally retarded, have been assured normal intelligence and healthy growth. The four are heirs to phenylketonuria (PKU).

They were rescued by the Michigan "Program for Mentally Retarded Children," centered at The University of Michigan Medical Center, and its intensive state-wide campaign to predict and prevent mental disease.

According to Richard J. Allen, M.D., U-M pediatric neurologist and director of the program, the groundwork for saving the four children was laid less than three years ago when the program initiated a continuing survey of Michigan's mentally ill. The study revealed about 100 cases of clearly-defined PKU among the number of other mental diseases that beset Michigan.

PKU is an inherited disorder, and so physicians, psychologists and social workers from across the state interviewed and examined all family members of the victims uncovered by the survey. Special interest focused on newly pregnant mothers within the families. On delivery at various hospitals throughout the state, the babies were tested with special blood tests.

The four found to have PKU were diagnosed within days after birth and immediately placed on a special corrective diet. Dr. Allen says, "These four children will presumably grow to normal, intelligent adulthood. If they had gone untreated longer than six months, some degree of abnormality probably would have resulted."

The Central Registry of all known PKU victims is located at the U-M Medical Center. The Michigan Program is aided by the Children's Bureau of the Department of Health, Education and Welfare.

Dr. Allen said it is believed to be one of the first statewide efforts of its kind to combat this type of mental illness. He predicts that in the near future, when all physicians in the state are acquainted with the disease and perform the necessary early and accurate diagnosis, PKU will be controlled.

the blue shield **record**

News in the field of prepaid health care for the doctors of Michigan

SPECIAL ANNUAL EDITION

For

MSMS JOURNAL, JUNE 1961

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THE CASE OF "THE BLURRED IMAGE"

G. THOMAS McKEAN, PRESIDENT
MICHIGAN MEDICAL SERVICE
READING TIME: 3 MINUTES, 15 SECONDS

The masthead on the cover of this Blue Shield Section should be very familiar to all in Michigan Medicine. It is, of course, the masthead of the monthly *Blue Shield Record.* The *Record* has become the prime instrument for communicating regular monthly information about prepayment and Blue Shield activity to Michigan's medical profession.

Thus it serves as the symbol of this special section of the June issue of the MSMS Journal devoted to capsuling a year of activities and developments within Blue Shield itself.

Out of the past year's activities in Medicine and in medical prepayment have emerged several inescapable facts:

1. The general public's images of the doctor and of the prepayment programs like Blue Shield have become blurred.

2. The images must be cleared and the record set straight. The interrelation of the public, Blue Shield and the individual doctor is the general theme of this special Blue Shield section this year.

Varying articles in it express perhaps widely divergent views in detail, but the thread is clear: the only finally effective public relations for the medical profession—whether it concerns Medicine's image or Blue Shield's —is the grassroots contact between doctor and patient on the individual level. In a word, "Mirror, mirror on the wall, who is fairest of them all?"

Only each doctor individually can answer that question about Medicine and Blue Shield for each of his patients.

Knowledge, sincere goodwill and dedication: these have been and always will be the doctor's basic tools in both his medical and socio-economic relationships with his patients. These can be utilized effectively only on a personal, doctor-patient basis.

Some of us—perhaps a substantial number of us in the profession—have tended to delegate this basic personal relationship with many of our patients to public relations technicians in our perfectly normal determination to utilize our time to choose and use the enormous range of clinical weapons at our disposal. Amidst clinical plenty we must improve, or in some cases re-establish a personalized doctor-patient relationship which has been sacrificed, albeit unintentionally, to clinical efficiency.

A perusal of the public press, popular magazines and some of the rather numerous Blue Cross and Blue Shield rate hearings around the country makes it quite evident a substantial number of people and a substantial number of articulate groups have serious misconceptions about both organized medicine and medically-oriented prepayment like Blue Shield.

The problem is that fact is not absolute; it is relative and it is emotional. The fact that, in general, doctor's fees are fair and reasonable and that "abuse" and misuse of prepayment programs are greatly overrated by the public and many articulate groups doesn't solve the problem.

The damaging "fact" is that these people believe only what they want to believe. The public tends to believe that doctor fees are too high and that abuse is widespread in Blue Shield.

In short, truth is not absolute. Truth, practically speaking, is what people believe is true. So whether we like it or not, we in the medical profession must accept the fact that an important number of persons believe that doctors overcharge and that Blue Shield is abused both by other members and by the doctors.

I think once we understand that even though people really recognize that today's medical care costs more, they don't really *like* to pay it and thus are subconsciously eager to find a scapegoat, then I think we as doctors can get out of a subjective atmosphere of our own and approach the problem objectively.

Once we achieve this objectivity, it is comparatively easy to recognize that in such an emotional atmosphere, "one bad apple"can spoil the whole barrel. We must:

1. Be sure individually that we do not ever "take advantage" of the Blue Shield program.

2. Recognize that controls and checks on use instituted by Blue Shield are necessary to prevent even the "one bad apple." Our program must also convey to the general public that there are effective controls against possible abuse and that the profession subscribes to them and supports them.

This, I feel very strongly, is a positive approach. It requires that we close ranks. Every physician as an individual should prove by example what is true about medicine and prepayment. Only this way, I am convinced, can we change the concept of truth about medicine and prepayment to what it ought to be in the general mind of the public.

In the specific realm of Blue Shield, we can work for ever greater inter-communication between Blue Shield, the doctor and our subscribers.

But we in Blue Shield can go no further than to suggest and to furnish the tools of knowledge about Blue Shield to the doctors.

We can work no public relations miracle. We *can and must* educate the subscriber to his benefits and their value. We *can* furnish the medical profession with the facts about Blue Shield. It then rests with the profession —collectively, but more important, individually—to use all the tools wisely.

Then Blue Shield, with the cooperation of the profession itself recognizing the need for effective self-discipline, will embody a positive program which will establish with the public the true dimension of prepaid medical care.

I believe the balance of this report will help lend depth and perspective to the problems we face. I believe the basic job is to establish as "public fact" what we in medicine believe to be "true fact." What is that? Namely that properly disciplined and intelligently receptive to change, the American system of "free-choice" medical practice and a voluntary prepayment system for financing medical care costs is the only way we shall continue to provide the best and most dynamic medical care to the American people. Failure to live up to that and to warrant public acceptance can only lead to another kind of medicine—in our time. To allow this to happen would be a disservice to both the medical profession and the public.



G. Thomas McKean, M.D., President
Michigan Medical Service

ENROLLMENT HOLDS STEADY IN 1960

READING TIME: 1 MINUTE, 15 SECONDS

Before analyzing briefly the Michigan Blue Shield enrollment figures for 1960 detailed on the next two pages, let us again point out that a distinguishing characteristic of Blue Shield is the basic principle of social responsibility it embodies in its method of "Community Rating."

The aim, of course, is to try to meet equitably the health care needs of the entire community. Thus Blue Shield sets its subscription rate on the overall average for all groups it enrolls. This becomes a "community" average including big groups and small groups; those with "good" experience (i.e., low claim rate) and those with "bad" experience (i.e., high claim rate).

This philosophy, competing with commercial "experience-rating" principles of setting individual rates for individual groups, means we at times "lose" groups already enrolled. But in the long run, as the figures indicate, Blue Shield enrollment stays on an even keel. Both major industry and labor have subscribed for many years to the social wisdom and long-run economic advantage to the community of community-rating.

Practically speaking, Blue Shield enrollment held steady last year. You will note that the total Michigan enrollment actually underwritten under MMS contracts was 3,449,650. However, an additional 82,000 are underwritten through other Blue Shield Plans—principally some of the "Steel" groups and more than 68,672 federal employees.

Actually most of these federal workers, before the July 1960 national uniform contract went into effect, were enrolled in the Michigan plan and were included in the Michigan figure for the previous year which stood at 3,518,322. Practically speaking, these groups serviced by MMS should be included in any figure totaling Blue Shield coverage in Michigan. As you will note, when this is done, the total Blue Shield coverage figure as of January 1, 1961 was 3,531,151 which is 12,000 higher than for that date in 1960.

Also of particular interest is the fact that 85% of all Michigan Blue Shield enrollment is under the M-75 group contributory certificates. Moreover, of the nearly 3,000,000 thus covered, over 50% (50.89%) are in Plan "C", the $5,000 to $7,499 income ceiling with the highest fee schedule. Some 15% are in Plan "D" ($7,500 and over) while only 8.24% (mostly group retirees) are in Plan "A" (under $2,500). The remaining 25.88% are in Plan "B" whose income range is $2,500 to $4,999.

M-75 GROUP	CONTRACTS	MEMBERS
M-75 Group		
Plan A	123,622	240,242
Plan B	295,842	754,595
Plan C	457,409	1,484,027
Plan D	123,075	437,004
Sub-total	999,948	2,915,868
M-75 Group Deductible		
Plan A	61	99
Plan B	388	1,047
Plan C	303	1,038
Plan D	171	583
Sub-total	923	2,767
Pending (Group Rates & Benefits)	8,160	23,590
Sponsor Dependent Rider		6,974
Family Continuation Rider		3,385
Total M-75 Group	1,009,031	2,952,584

M-75 GROUP CONVERSION

M-75 Group Conversion		
Plan A	72,987	110,771
Plan B	38,858	90,889
Plan C	14,110	40,181
Plan D	5,148	14,797
Sub-total	131,103	256,638
M-75 Deductible Group Conversion		
Plan A	2,482	4,512
Plan B	1,978	5,423
Plan C	857	2,734
Plan D	417	1,281
Sub-total	5,734	13,950
Sponsor Dependent Rider		67
TOTAL M-75 Group Conversion	136,837	270,655

M-75 NON-GROUP	CONTRACTS	MEMBERS
M-75 (Under Age 65)		
Plan A	52,268	87,423
Plan B	25,384	58,811
Plan C	8,895	26,132
Plan D	5,065	14,325
Sub-total	91,612	186,691
M-75 (Senior)		
Plan A only	15,317	15,317
Total M-75 Non-Group	106,929	202,008
TOTAL M-75	1,252,797	3,425,247

$2,500 GROUP		
Surgical	2,676	5,981
Medical-Surgical	1,894	5,302
Sub-total	4,570	11,283

$5,000 GROUP		
Surgical	932	3,174
Medical-Surgical	3,292	9,770
Sub-total	4,224	12,944
Pending (Group Rates & Benefits)	64	176
TOTAL $2,500-$5,000	8,858	24,403

TOTAL MICHIGAN BLUE SHIELD ENROLLMENT	1,261,655	3,449,650
Additional Enrollment Serviced by MMS		
Federal Employees	21,260	63,511
Others	5,161	17,990
GRAND TOTAL	1,288,076	3,531,151

MORE MEMBERS NEED AND GET MORE SERVICES

READING TIME: 1 MINUTE, 5 SECONDS

The two tables on the opposite page tell what's happening in the field of medical care — both as to the increase in the number of services per 1,000 persons and in the pattern of increased cost in prepayment.

Remember that the *fees* for the services paid by Blue Shield *remain the same.* It is the need for more services by members that increases the *cost,* and thus periodically, the Blue Shield subscription rate.

Notice that the tables break the services provided by Michigan Blue Shield into 10 major components. They provide a comparison of the 1st nine-month period of 1959 with the 1st nine-month period of 1960.

The tables first compare the *number of services per 1,000 members* and the increase. As you will note, it shows the percent of increase for each of the 10 services over the previous period and an average overall increase of services per 1,000 members of 12.14%. There is a final column labeled "weight" of increase. It shows the degree — based on a total of 100% — which each component's increase actually contributed to the over-all increase figure of 12.14%.

In short, take anesthesia. It had an individual increase of 11.75% of 1960 over 1959. But its frequency in relation to all other components was low and its 11.75 increase only represented 4.31% of the 100% value of the total increase.

On the other hand, "surgery" with a high frequency in relation to other components, had only a 7.04 percent increase individually, but this accounted for 18.91% of the 100% value of the total increase.

The second table compares the *cost of services and administrative expense* and the increase. It involves the same 10 services over the same comparative periods. Note that because the highest increases in *services* occurred in *lower-cost* components, that the overall increase in *cost-per-1,000 members* is 6.37 percent although the *frequency* of services increased 12.14 percent.

Again, the pattern of the tables is identical, with the last column showing the degree—based on a total of 100%—which each component's increase actually contributed to the over-all increase figure of 6.37% in *cost.*

MICHIGAN MEDICAL SERVICE

FREQUENCY OF SERVICE UNDER THE M-75 CONTRIBUTORY SERIES GROUP AND GROUP CONVERSION CONTRACTS

COMPARISON OF INCURRED 1st 9 MONTHS OF 1959 AND 1st 9 MONTHS OF 1960

Component	Frequency of Service Per 1000 Members Per Year 1959	1960	Increase (Number)	Percent of Increase Over 1959	Weight (Percent of Total Increase)
Surgery	219.73	235.21	15.48	7.04%	18.91%
Obstetrical	21.66	22.42	.76	3.51	.93
Medical	68.82	72.79	3.97	5.77	4.85
Anesthesia	30.03	33.56	3.53	11.75	4.31
Diagnostic X-Ray	268.10	303.39	35.29	13.16	43.09
Radiation Therapy	2.12	2.68	.56	26.41	.68
EKG-BMR-EEG	47.27	59.55	12.28	25.98	15.00
Pathology	7.00	12.03	5.03	71.86	6.14
Consultation	7.88	11.19	3.31	42.01	4.04
Technical Surgical Assistance	2.00	3.68	1.68	84.00	2.05
Total	674.61	756.50	81.89	12.14%	100.00%

MICHIGAN MEDICAL SERVICE

COST OF SERVICES AND ADMINISTRATION EXPENSE M-75 CONTRIBUTORY SERIES GROUP AND GROUP CONVERSION CONTRACTS

COMPARISON OF INCURRED 1st 9 MONTHS OF 1959 AND 1st 9 MONTHS OF 1960

Component	Cost of Service Per 1000 Members Per Year 1959	1960	Increase (Amount)	Percent of Increase Over 1959	Weight (Percent of Total Increase)
Surgery	$10,666	$11,023	$ 357	3.35%	23.83%
Obstetrical	1,968	2,000	32	1.63	2.13
Medical	4,420	4,507	87	1.97	5.81
Anesthesia	907	997	90	9.92	6.01
Diagnostic X-Ray	3,249	3,657	408	12.56	27.24
Radiation Therapy	181	228	47	25.97	3.14
EKG-BMR-EEG	459	573	114	24.84	7.61
Pathology	40	60	20	50.00	1.34
Consultation	78	130	52	66.67	3.47
Technical Surgical Assistance	55	91	36	65.45	2.40
Total	22,023	23,266	1243	5.64	82.98
Administration	1,490	1,745	255	17.11	17.02
Grand Total	$23,513	$25,011	1498	6.37%	100.00%

UTILIZATION CONTROLS: PAST, PRESENT AND FUTURE

READING TIME: 3 MINUTES, 25 SECONDS

At the time Michigan Medical Service filed for a 19.5% rate increase in May of 1960 to hold for a two-year period, the Commissioner of Insurance slashed the amount to 11.5%. He frankly stated in his ruling and directive that the 11.5% was estimated to last only one year and allowed no provision for rebuilding a non-existent Contingency Reserve.

To explain his action, he declared that "many of our citizens hold to the opinion that prepayment plans have been abused in such areas as . . . payments by Blue Shield for services not rendered and excessive use of diagnostic services.

"*We are not in a position to determine the extent and relative importance that should be assessed to these factors,*" the Commissioner said, "but careful review of these, as well as other areas, should be undertaken and procedures established to prevent misuse or abuse." This should involve a program, he said to "minimize rising costs to subscribers and provide a more stable rate and benefits structure."

Two points about this are crystal-clear: the general public believes there is considerable "abuse" yet not even the Commissioner feels he is in a position to measure and declare its extent.

The facts, very briefly, are these: Michigan Medical Service for many years before this directive has utilized several effective deterrents to so-called misuse. So has companion Michigan Hospital Service in the area of misuse of hospital care benefits.

In addition, since May of 1960, old measures have been strengthened, new ones instituted and a constant broadening of these programs is envisioned in the future. Such programs are not designed as punitive action on the medical profession as a whole, but a safeguard against the occasional offender whose action can taint the vast majority who do not misuse the program.

Such programs are actually to the great advantage of the majority of the medical profession because their long-range effect will be to establish in the public mind that Michigan Blue Shield is properly and efficiently run. And perhaps, even more importantly, that the medical profession is NOT misusing or abusing Blue Shield at the expense of the subscribers.

Moreover, knowledge and publicity concerning such "control" programs helps educate the subscriber not to put pressure on the physician for needless use of Blue Shield benefits. It puts an effective weapon in the hands of a doctor faced with this kind of patient pressure also. The doctor is in a much sounder position to declare with no equivocation that "it just can't be done," because Blue Shield has effective methods for discovering and rejecting payment on unnecessary or improperly reported services.

When Michigan Medical Service filed in January of 1961 a request for a rate increase, there was, in accordance with the Insurance Commissioner's 1960 directive, an extensive and detailed section meeting his request to review and establish procedures to prevent misuse or abuse.

Here are some of the main points excerpted from that section to serve as a brief resume of the MMS Utilization Control Programs, past, present and future.

First of all, MMS for several years has sent a copy of the Doctor's Service Report to the subscriber. This subscriber's copy specifies the date of service; the general nature of the service (i.e., surgical, obstetrical, in-hospital medical care); and the doctor reporting and being paid for the service. It also suggests that if the subscriber feels there is any discrepancy or there is something he does not understand, he should report it to MMS to be checked.

This is a basic control instrument extremely effective in areas of actual attempted fraud. Now, as it is tied in directly with the relatively-new "Utilization and Liability Control Activity," it is gaining quickly as a major source of prompt, thorough investigation of complaints. This has meant, too, that both the subscriber and the doctor are assured speedy and accurate evaluation of complaints.

2. Monthly comparison audit of doctor-office reported procedures using IBM and electronic tapes of the MMS data processing center. This gives a comparison of frequency of procedures for each doctor. This has proved to be a most productive technique of case-finding and checking to date. Obviously this first provides only raw data which must be carefully evaluated. For example, specialists in a given field are naturally and expectedly going to have more than the average for certain procedures in their field of specialty. But someone outside that field with an above-normal number of that procedure warrants some closer checking.

3. Careful thorough investigation of complaints. This stems in part from the complaints triggered by the subscriber copies of the Doctor's Service Reports. It also involved wholly unsolicited complaints from

various sources including doctors, boards of registration, the insurance department and even commercial insurance firms checking into double-coverage cases which have aroused their interest.

These investigations also involve an average of 500 random-sample subscriber letters sent out monthly which are really questionnaires-in-depth about satisfaction or dissatisfaction with Blue Shield and the way services were rendered and covered.

4. Suggested for the immediate future is institution of a state-wide system of Audit and Review Committees on hospital staffs. It is hoped these would function to make determinations of liability for both Blue Shield and Blue Cross in such areas as diagnostic admissions, concurrent medical care, overstays and unnecessary hospitalization as well as helping perform random sample or complete audits of hospital cases.

Naturally much of the success of this kind of "control program" outlined lies in communication about it and direct knowledge of it both by the medical profession and the subscriber. Michigan Medical Service has stepped up its communications-flow with the profession through the monthly "Blue Shield Record," the 125 Liaison Committees, a stepped-up program of talks by Blue Shield board members and professional relations representatives, specific letter-reports by MMS officials and the special Utilization and Liability Control Committee of the Board of Directors.

Similarly all available communications channels between MMS and its subscribers are being implemented and strengthened. There is no question but that these strengthened and expanding utilization control programs assure the members, the medical profession and the general public that all possible avenues of misuse are being effectively blocked.

LIAISON COMMITTEES: A PERSON-TO-PERSON APPROACH

READING TIME: 2 MINUTES, 40 SECONDS

Communication, as most of the articles in this section emphasize, is the basis of understanding and basic public relations. Dr. McKean indicated in his opening article in the section that the more personal, the more individual the contact between Blue Shield, the doctor and the patient, the more effective the result.

The problem of communication of ideas, of policy, of financial, political and marketing problems between Blue Shield and the doctor became steadily more acute as the plan grew. In late 1959, the Board of Directors set up a Professional Relations Committee to take a long, hard look at what might be done to solve these problems.

The Committee in early 1960 discovered from a state-wide survey that despite three years work on the M-75 program by the House of Delegates and wide publicity given it, the average physician in Michigan had little understanding of the policy responsibility of the MMS Board of Directors and little knowledge of the reasons behind policy decisions by Blue Shield.

Much material was being produced directly by Blue Shield in various publications media for the doctors and much was carried in the Medical Journals. The problem seemed to be lack of intimate interest by the individual physician.

The committee decided the most effective technique must be based on a direct, personal, person-to-person approach.

Therefore, in mid-1960 letters were sent to the chief of staff of every hospital and to the president of every county medical society requesting the appointment of a Professional Relations Liaison Committee with Michigan Medical Service. Aim: to establish better and more intimate contact and communication between MMS and the doctors.

The impact of this letter, plus the personal efforts of members of the Professional Relations Committee and the MMS Professional Relations Staff, in the last six months have been highly successful.

Today there are more than 125 such liaison committees. In urban areas, they are usually at hospital staff level. This helps keep them small and intimate. In less populated centers, they are at the county medical society level.

This is a heartening start. It indicates that the idea works and has

grass-roots acceptance. There are, of course, areas where committees are not yet established. There is still considerable variance in interest and effective accomplishment, taking one committee against another. But it is reasonable to assume that the success and enthusiasm of the majority will be infective and spread statewide within the year.

Of obvious interest, of course, is how these liaison committees work and what is the general method of communication-flow between them and the individual doctor. In reverse it is important what avenues exist between the individual doctor and Blue Shield.

Quite briefly, it is this: As soon as MMS is informed that a committee has been established, the Blue Shield Professional Relations representative in that area visits the chairman. They arrange convenient meetings to follow each MMS board meeting.

At such meetings, the MMS representative has been thoroughly briefed so he can discuss all points of the Blue Shield board action he reports. Moreover, each committee member gets a resume of the minutes of the board meeting. From that comes a flow of questions and answers. At such meetings news items and articles of opinion on the medical economics picture are also brought to the liaison committee's attention.

In short, the MMS representative at such a meeting tries to keep members informed not only of the specific actions of the MMS board of directors, but the reasons behind the actions.

The meeting, however, is just the first step in an effective liaison committee. The committee members are asked to report back to their county medical group or hospital staff what information they've received. By the same token, they are asked to relay back to the MMS representative criticisms or suggestions they get from their colleagues.

The Professional Relations Committee feels that the activities of these liaison committees in the short few months the program has been in existence have stimulated interest and discussion among the practicing physicians. And it is they who in the long run must individually make the necessary and critical choices between alternative answers to the future economics of American Medicine.

The Committee, of course, realizes that the effort to date is not reaching every physician in Michigan. But that is the goal. The Committee hopes that soon every medical society and every hospital staff will have liaison committees to help get material and ideas to and from the physicians in a steady flow. Then decisions will be based on a fuller knowledge and understanding of the problems physicians and Blue Shield face together.

MEDICINE'S CONCERN FOR AGED IS LONGSTANDING

AN EDITORIAL
BY EDWARD ANNIS, M.D.
READING TIME: 1 MINUTE, 10 SECONDS

It takes a bit of doing these days to separate the wheat from the chaff in this broad question of medical care and medical care costs, particularly as they apply to the aged. In the full bloom of this newly-found issue of the politicians, too many persons lose sight of the simple fact that the history of medicine in America is one in which the doctors of this country have been taking care of people.

For many, many years, the medical profession has been in the forefront of those who have felt that every man, every woman, every child in America should have the finest medical care when needed.

Medicine's concern for the elderly has always existed. It did not start with doctors—as it has with certain people in the political arena—just a few years ago. This recent concern by some with political motives and ideas coincides strangely with the fact that they now represent 16-million votes. Incidentally, the doctors have considerable responsibility for those 16-million votes; we're very proud of them. We know that since the turn of the century we've added 20 years in average life expectancy in this country.

Moreover, we in the profession feel that the government does have a responsibility to help people who cannot help themselves. This is the reason we have supported the Kerr-Mills law, which states that those people who need help should have help.

I am unalterably opposed to the social security approach. First, because it is an approach that benefits the rich as well as the poor. Second, because it is a poor man's tax. Forty percent of the nation's income is not subject to social security and the poor man with an income of $4,000 to $5,000 a year pays disproportionately into the fund. Third, I feel strongly that this is socialized medicine for the growing segment of our population over 65.

Note that every bill that has been introduced lays down provisions that services shall be provided by those hospitals and those individuals *under contract with the federal government under rules and regulations prescribed by the federal government.* This to me is socialized medicine for the doctors—and if we have it for the doctors, we shall soon have socialized medicine for the patients.

THE OTHER SIDE OF THE "COST-USE" COIN

READING TIME: 5 MINUTES, 10 SECONDS

Keats Vining, M.D., a Grand Rapids internist, requested at the Blue Cross-Blue Shield rate increase hearing in Grand Rapids last February 15th that he be heard from the floor simply as an individual physician. Here are excerpts of the highlights of his extemporaneous remarks:

"I am not speaking here to represent the medical profession. I am speaking as an individual physician. I have read with great interest the minutes of this type of hearing when held in Detroit and others in the past years every time a rate increase becomes necessary for Blue Cross-Blue Shield. This time I have become fed up with hearing the various statements about mal-use, over-utilization and abuse by hospitals and doctors, and I have decided it was time someone who was practicing medicine placed a few salient facts on the table for consideration when discussing the need for rate increases.

"Now it is true, and no one will deny it, that the cost of medical care has gone way up in the last 10 years, just as in the last 50 years if you want to go back that far . . . I am not here to apologize for its going up. I am here to brag about the increase in cost to anyone who carries health insurance, because you have never bought so much for so little in your life, and you will never buy so much for so little in any other aspect of living. What am I trying to say? Just this:

"I recently had in the hospital a 21-year old boy with a bizarre type of heart disease. I had followed his case for 10 years. We could not put our finger on exactly what it was 10 years ago—we did not have the equipment or the know-how. But fortunately in the past 10 years big medical centers like Johns Hopkins, Mayo Clinic and the University of Michigan Medical Center have been doing a real crash program on coming through with means of answering these questions.

"Now we take such a patient through a procedure called cardiac catheterization, in which we put a tube from the outside of the body to the inside of the heart to measure variations in saturation of the blood with oxygen in the four chambers of the heart. We measure the variation in pressures within the four chambers, we measure the blood flow back and forth to find out where it is going that it should not go, and how much is going there. The room in which this is done is equipped with

complicated x-ray equipment and a machine that will take six pictures a second as a radio opaque dye flows through the heart. It reveals afterward where it was. There is also a machine that records electronically the exact pressures at various times and still another machine that samples the blood for oxygen content.

Well, I think I have said enough to show you that this procedure is fabulously expensive when compared to listening through a stethoscope which you can buy for $4.50, not to mention the cost of the training of the man who is listening. We made a diagnosis on this boy. A hole existed between the two auricles of his heart. He was born with this. We knew exactly how big that hole was and how much material it was going to take to fill that hole, and how it should be done.

At the right time and the right age, he was taken to the operating room. His arterial system was disconnected from his heart and connected to an artificial heart which kept the blood circulating. He was connected to an artificial lung which kept the right amount of oxygen in his blood. Then his chest was opened and his heart opened wide so the surgeon could see the defect, knowing ahead of time how big a patch he needed. He had it ready and it was sewed in.

Then the heart was closed, the chest was closed, the artificial pump was unplugged and the artificial lung disconnected. All this time electronic computers and scanning equipment were telling the surgeon and the physiologist and the internist exactly what was happening . . .

"The Mayo Clinic published a cost breakdown on one of these procedures a few years ago.

Sixteen people were involved for eight hours. Amortizing the cost of the equipment and the personnel, it cost someone $50,000 for one such operation. No one pays $50,000 for such a procedure today. The cost is partly defrayed by endowments and special grants. It is partially defrayed by general hospital income. *However, it has to be paid for as a part of modern medical care.* Five years ago we could not do this procedure . . . the equipment was not available. Today it is available and in two of our Grand Rapids hospitals this procedure can be carried out when indicated."

Dr. Vining cited two other dramatic cases in point. One involved a friend who eight years ago suffered severe chest injuries in an auto accident and could not breathe for himself. He died in 48 hours. Five years later a man in Chicago developed a machine that connects through the trachea and breathes for a victim until the surgeon can repair the crushed chest.

It came too late for Dr. Vining's friend. But it is now used time and again in the hospital's "intensive care unit" at Grand Rapids.

And Dr. Vining added:

"The machine alone costs $1,500. There are now three of them on hand for such emergencies and nobody is without this help. We have to have nurses in this intense care unit, one nurse for practically every patient, highly technically trained specialists in this type of nursing care.

"Now we may have six or seven nurses on duty that are not working, but we have them there because somebody may clobber somebody else in an auto accident out on M-16 and we may have five serious accident cases in ten minutes. *It costs a lot more money than when we just brought all patients to the emergency room for terminal relief of pain because we could do no more than just that.*"

The second case Dr. Vining cited involved kidney failure due to an unknown toxic substance.

"Five years ago," Dr. Vining told the Hearing, "such a patient would be dead in 48 to 72 hours . . . But now, and in this case, we had an artificial kidney. We've also developed a complicated alternate method in which we run fluids through the peritoneal cavity with electrolyte and complicated bio-chemical control . . . Point is we had it, this patient stayed under these controls for three solid weeks with around the clock nursing and tests requiring the work of many, many people for many hours.

"But he is alive and working this afternoon. He is 48 years old and back on his feet able to care for his wife and four children. Five years ago his wife would have been out looking for a job. Her husband would have been buried within the week."

". . . Now I submit that we can hold the line for five years and make no further advances. If you are satisfied with the quality of medical care today, if that is what you mean when you say you cannot pay any more insurance, we can stop here. But you are not going to say it and you are going to want the best medical care and the medical profession is going to want to give you the best and most advanced care . . .

"I am tired of having people say that overutilization is the reason for increase cost. I am tired of having people say that doctors are not honest about this thing. I submit to you that the percentage of honest and dishonest doctors in the medical profession is probably not significantly different from the percentage of honest and dishonest labor leaders, honest or dishonest lawyers, or honest or dishonest bricklayers . . .

"I submit to you that the increments of misuse of anything, whether it be the hand you hold in a poker game; the insurance for repairing your car when it is damaged; or whether it be the hospital-medical coverage you carry, it is an insignificantly small amount. If you base your decisions and conclusions on that, it means you are being led astray.

"The reasons for the increased cost of medical care from the time of Hippocrates has been increased knowledge of what to do and increased ability to do it. Unfortunately, the more you can do to keep people healthy and alive, the more it is going to cost people to stay that way and take advanage of it. I think the Insurance Commissioner should know this, and I want to say it for the record.

"When you feel you must criticize the increased cost of your health care then think—Do you want your grandson who may be born with a congenital heart defect to be denied the opportunity to have it corrected and live a healthy, normal life? Do you want your husband or wife if exposed to a kidney toxin to just die for lack of something which could save them?

"If you ask medicine and research to hold the line and not let it get any more expensive—or if you ask us to decrease the cost back to three years ago, then we have to run some red pencils through some of these things we can do today. We will have to say "no" to the new advances that are just around the corner. We say "no" because people say they can't afford them.

"But as a doctor I can say we do not want to do these things and I can assure you we are not going to do them. We are going to fight for every bit of improvement in medical care possible, and we are going to come right back at you and tell you why it is costing more.

"We cannot promise you that medical care is going to get cheaper. Actually we will openly tell you that it is probaby going to get more expensive.

"We CAN promise you that medical care is going to become better and that it is going to become more effective in keeping you healthy and saving your lives. So ask yourself if life and health is worth it.

"If it is, the answer is that you are going to have to pay more for it. I do not care if you pay more to Blue Cross-Blue Shield, or an increased premium to Continental Casualty or the Aetna Company. They are all going to come back at you for more money for your coverage, or you are going to have to dig deeper into your own hip pocket if you pay straight costs yourself. I do not care what method of payment you utilize, the cost is going to go up. You might just as well face it."

MICHIGAN MEDICAL SERVICE

PAYMENTS FOR SERVICES TO SUBSCRIBERS BY RESIDENCE OF DOCTORS OF MEDICINE FOR YEAR 1960

		Participating 12/31/60	Non-Participating 12/31/60	Percent of Total
1.	Alcona	$ 3,171	—0—	.01
2.	Alger	19,162	—0—	.03
3.	Allegan	70,645	$ 7,841	.13
4.	Alpena	261,933	—0—	.42
5.	Antrim	8,506	—0—	.01
6.	Arenac	31,512	—0—	.05
7.	Baraga	46,740	—0—	.08
8.	Barry	44,673	—0—	.07
9.	Bay	780,845	214,730	1.61
10.	Benzie	41,361	10	.07
11.	Berrien	316,280	40,634	.58
12.	Branch	165,132	1,654	.27
13.	Calhoun	655,657	85,443	1.20
14.	Cass	18,645	30	.03
15.	Charlevoix	53,990	—0—	.09
16.	Cheboygan	86,144	—0—	.14
17.	Chippewa	290,464	—0—	.47
18.	Clare	12,029	191	.02
19.	Clinton	189,648	2,360	.31
20.	Crawford	58,395	6,885	.11
21.	Delta	55,831	12	.09
22.	Dickinson	79,304	14,919	.15
23.	Eaton	177,688	178	.29
24.	Emmett	71,407	219,485	.47
25.	Genesee	553,126	4,413,072	8.01
26.	Gladwin	58,754	—0—	.09
27.	Gogebic	65,486	55	.11
28.	Grand Traverse	241,768	133,922	.61
29.	Gratiot	100,668	21,397	.20
30.	Hillsdale	122,173	1,127	.20
31.	Houghton	117,132	—0—	.19
32.	Huron	170,024	10	.27
33.	Ingham	2,003,317	438,301	3.93
34.	Ionia	169,759	4,938	.28
35.	Iosco	88,027	21,173	.18
36.	Iron	17,291	—0—	.03
37.	Isabella	264,414	—0—	.43
38.	Jackson	484,573	55,021	.87
39.	Kalamazoo	500,099	154,646	1.06
40.	Kalkaska	4,897	—0—	.01
41.	Kent	1,897,320	273,823	3.50
42.	Keweenaw	30,856	—0—	.04

MICHIGAN MEDICAL SERVICE

PAYMENTS FOR SERVICES TO SUBSCRIBERS BY RESIDENCE OF DOCTORS OF MEDICINE FOR YEAR 1960 (Continued)

		Participating 12/31/60	Non-Participating 12/31/60	Percent of Total
43.	Lake	$ 71	$ —0—	.00
44.	Lapeer	250,277	28,553	.45
45.	Leelanaw	24,007	17,347	.07
46.	Lenawee	320,216	—0—	.52
47.	Livingston	154,776	20	.25
48.	Luce	40,939	—0—	.07
49.	Mackinaw	12,935	5	.02
50.	Macomb	1,179,840	317,364	2.42
51.	Manistee	62,531	660	.10
52.	Marquette	296,844	47,463	.56
53.	Mason	59,634	12,041	.12
54.	Mecosta	76,679	—0—	.12
55.	Menominee	43,162	—0—	.07
56.	Midland	17,526	9,177	.04
57.	Missaukee	47,923	—0—	.08
58.	Monroe	188,994	4,320	.31
59.	Montcalm	138,506	9,128	.24
60.	Montmorency	255	491	.00
61.	Muskegon	236,051	61,379	.48
62.	Newago	79,538	—0—	.13
63.	Oakland	2,976,267	1,874,479	7.83
64.	Oceana	62,785	—0—	.10
65.	Ogemaw	75,325	—0—	.12
66.	Ontonagon	39,611	—0—	.06
67.	Osceola	61,504	—0—	.10
68.	Oscoda	632	—0—	.00
69.	Otsego	42,820	—0—	.07
70.	Ottawa	206,595	3,566	.34
71.	Presque Isle	62,642	—0—	.10
72.	Roscommon	8,139	—0—	.01
73.	Saginaw	1,827,763	169,371	3.23
74.	St. Clair	703,199	63,192	1.24
75.	St. Joseph	97,905	—0—	.16
76.	Sanilac	79,470	1,450	.13
77.	Schoolcraft	38,898	—0—	.06
78.	Shiawassee	347,367	86,502	.70
79.	Tuscola	115,739	—0—	.19
80.	Van Buren	192,909	—0—	.31
81.	Washtenaw	2,722,766	181,337	4.69
82.	Wayne	18,860,884	10,587,450	47.55
83.	Wexford	156,606	93	.25
	TOTAL	$42,339,376	$19,587,245	100.00

MICHIGAN MEDICAL SERVICE

PAYMENTS FOR SERVICES TO SUBSCRIBERS BY RESIDENCE OF DOCTORS OF OSTEOPATHY FOR YEAR 1960

		Amount	Percent of Total
1.	Alcona	—0—	
2.	Alger	—0—	
3.	Allegan	$ 436	.00
4.	Alpena	—0—	
5.	Antrim	5,172	.05
6.	Arenac	15,471	.15
7.	Baraga	200	.00
8.	Barry	4,962	.05
9.	Bay	75,082	.72
10.	Benzie	1,975	.02
11.	Berrien	11,693	.11
12.	Branch	4,594	.04
13.	Calhoun	65,846	.63
14.	Cass	83	.00
15.	Charlevoix	—0—	
16.	Cheboygan	41	.00
17.	Chippewa	290	.00
18.	Clare	60,431	.58
19.	Clinton	12,305	.12
20.	Crawford	3,760	.04
21.	Delta	—0—	
22.	Dickinson	—0—	
23.	Eaton	25,454	.24
24.	Emmett	32,823	.32
25.	Genesee	1,403,309	13.48
26.	Gladwin	4,075	.04
27.	Gogebic	229	.00
28.	Grand Traverse	55,834	.54
29.	Gratiot	23,451	.23
30.	Hillsdale	8,029	.08
31.	Houghton	—0—	
32.	Huron	33,137	.32
33.	Ingham	351,149	3.38
34.	Ionia	22,367	.21
35.	Iosco	9,567	.09
36.	Iron	—0—	
37.	Isabella	14,505	.14
38.	Jackson	85,358	.82
39.	Kalamazoo	38,718	.37
40.	Kalakaska	—0—	
41.	Kent	273,479	2.63
42.	Keweenaw	—0—	
43.	Lake	$ 784	.01
44.	Lapeer	133,724	1.29
45.	Leelanaw	—0—	
46.	Lenawee	2,034	.02
47.	Livingston	41,634	.40
48.	Luce	—0—	
49.	Mackinac	4,781	.05
50.	Macomb	589,209	5.66
51.	Manistee	13,100	.13
52.	Marquette	—0—	
53.	Mason	21	.00
54.	Mecosta	19,132	.18
55.	Menominee	—0—	
56.	Midland	1,395	.01
57.	Missaukee	—0—	
58.	Monroe	26,086	.25
59.	Montcalm	114,203	1.10
60.	Montmorency	1,159	.01
61.	Muskegon	38,893	.37
62.	Newago	13	.00
63.	Oakland	1,346,348	12.94
64.	Oceana	—0—	
65.	Ogemaw	3,366	.04
66.	Ontonagon	—0—	
67.	Osceola	44	.00
68.	Oscoda	4,382	.04
69.	Otsego	1,294	.01
70.	Ottawa	4,668	.04
71.	Presque Isle	—0—	
72.	Roscommon	9,742	.09
73.	Saginaw	409,423	3.94
74.	St. Clair	15,129	.15
75.	St. Joseph	485	.01
76.	Sanilac	16,631	.16
77.	Schoolcraft	260	.00
78.	Shiawassee	27,814	.27
79.	Tuscola	38,873	.37
80.	Van Buren	906	.01
81.	Washtenaw	176,504	1.70
82.	Wayne	4,714,778	45.32
83.	Wexford	3,406	.03
	TOTAL	$10,404,046	100.00

SUMMARY OF 1960 PAYMENTS

	Amount	Percent of Total
Doctors of Medicine:		
Participating	$42,339,376	54.72%
Non-Participating	19,587,245	25.32
Total Michigan M.D.'s	61,926,621	80.04
Total Michigan Osteopaths	10,404,046	13.45
Out-of-State Doctors and Unclassified	5,031,993	6.51
Total Payments Year 1960	$77,362,660	100.00%

RATE INCREASE REPORT: COOPERATION IS THE BYWORD

READING TIME: 2 MINUTES, 40 SECONDS

In January of this year, Michigan Medical Service filed a request for a 13.5% rate increase. It was based on actuarial studies of the recent trends in increase in use of services. On the basis of those trends, it was the amount needed to wipe out a negative contingency reserve of nearly $2 million, set aside reserves of at least 3% of income and keep Blue Shield in the black for at least two years.

Insurance Commissioner Frank Blackford after three hearings in February and delays engendered by two union local officials, approved a 10% increase for Michigan Medical Service, effective June 1.

This was contingent upon Michigan Medical Service submitting a plan under which 3% of monthly income could be allocated to reserves and contingent upon MMS neither reducing benefits nor increasing fees in the fee schedule during the life of the increase.

Such a program was approved by the board of directors of Michigan Medical Service unanimously at the regular meeting on April 12, 1961. MMS noted in submitting its plan to the Commissioner that "your (the Commissioner's) report stated that Michigan Blue Shield ranks among the best in the country in terms of benefits provided members and low administrative costs."

The letter and plan to the Commissioner pointed out that Michigan Medical Service shares the same concern as the Commissioner over the rising costs of benefits, but observed also that the fee schedules developed in late 1957, remain substantially unchanged since the introduction of the M-75 program in late 1958.

To achieve a stable financial position and set aside 3% per month for a contingency reserve on the 10% increase granted will require full cooperation from the subscribers, from the medical profession and from Michigan Blue Shield.

This, you will note, has been the underlying theme of the preceding articles in this 1961 "Special Blue Shield Section" of the MSMS Journal.

Incidentally, in its letter to the Insurance Commissioner outlining the plan, MMS also pledged to promote maximum operating efficiency and continue to improve the effectiveness of the various "use-control" programs.

There have been some early indications that the joint efforts of Blue

Shield and the medical profession in the last few months have begun to bear fruit in a slight decline in the rate of increase of utilization.

As the other articles in this report show, many of the recommendations and suggestions of the Insurance Commissioner have been implemented and are being expanded with the effective cooperation of the physicians.

Kenneth Johnson, M.D., president of the Michigan State Medical Society, perhaps summed up the situation as realistically as it can be in a recent panel on "What Can the Hospitals, Doctors and Public Do to Hold the Line on Health Care Costs" before the Blue Cross-Blue Shield Member Council in Lansing.

Dr. Johnson in essence said that first of all, we need a general trend to reduce the costs—stem inflation—in everything.

Then, specifically in the field of medical care costs, he believes the public must bear its share by reducing its demands and letting the doctors see that *patients really are concerned about keeping costs down.*

He also believes, however, that the doctor must play a more militant role in this area.

"They (the doctors) are just going to have to make decisions in a lot of these areas and then not worry about it," he said.

They are going to have to be more resistant to ordering 'the latest thing' when it just isn't needed but the patient is pressuring because 'he's read about it somewhere'."

There is no question but that the reduction of the MMS increase request from 13.5% to 10% means that the public, the doctor and Blue Shield are going to have to work together to the end that every dollar is properly used while no dollar is spared for care that is needed.

Only through this kind of cooperation will Blue Shield stay financially sound yet maintain the high level of benefits both the public and the medical profession demand.

Paralysis Agitans Syndrome

A Report on the Results of Testing and Treatment With High Frequency (Sedac) Currents

Alfred E. Eyres, M.D.
Josephine Knight
Detroit, Michigan

Reuben Reiter, Sc.D.
New York, New York

THE high frequency (sedac) currents used in this treatment project have been defined and elaborated in a previous paper.[1] In this presentation, the terms "high frequency" and "sedac" will be used interchangeably. Briefly, the instrumentation utilized in production of the high frequency currents is the Reiter S.O.S. Electrostimulator. This instrument delivers, in the testing and treatment situation, variable bursts of current reaching to 1,000,000 cycles and much more. Power may be varied from a fraction of one sedac unit to 1,500 units. The sedac unit is a descriptive electronic term and serves as a substitute equivalent for highly complex mathematical formulation of many frequencies at various intensities. The principle followed in formulating the sedac unit is similar to that used in defining the Roentgen unit as the complex formulation of an x-ray beam.

In sharp contrast to galvanic current, the sedac currents are capable of stimulating both sensory and motor components throughout a wide range, yet remaining well under the pain discomfort threshold.

The high frequency currents were introduced into medicine about five years ago. They most certainly appear to have opened an entire new field for investigation. A number of investigators have published papers dealing with this subject.[2-15] Clinicians report effectivity of therapy in functional disorder, in organic psychiatric syndrome and in neurological entity.

Two years ago, two men with Parkinson's Disease, having sustained psychotic disorder, were admitted to the Psychiatric Service of the Jennings Memorial Hospital. They were placed on high frequency therapy. Each patient received four hours of treatment weekly over a period of four weeks. Not only did the psychotic situation lessen in intensity, the neurological symptoms were relieved. It was decided that it might be interesting and rewarding, as a pilot study, to test and treat a series of paralysis agitans patients (of as pure a neurological culture as possible).

A discussion of theory, mechanism, action and technique have been described and published previously.[1] A short explanation, however, is in order. As in other types of electrocerebral therapy, the specific action of high frequency current in the therapeutic procedure is unknown. The high frequency testing procedures are based upon the principle of "excitation." The minimum sensitivity and the maximum tolerance modalities constitute the extremes of the excitation factor. The first modality is defined as the sedac unit value noted when the patient first perceives the current. The second modality is the value noted at the upper limit of the pain discomfort threshold.

Sedac testing and treatment is instigated over many "brain areas" by varying the scalp leads. A single brain area may be tested or several areas may be together enveloped, tested and treated. The positive and negative lead set of wires emerging from the instrument may be made fast to the subject in either of two ways. If one electrode is fastened to an extremity (usually the right forearm) and the other is placed on a specific scalp area—the method is designated as *monopolar*. If both positive and negative electrodes are fastened to specific areas, the method is defined as *bipolar*.

The several brain areas may test and treat within



Author

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From the Grace Hospital, Detroit, Michigan.

TABLE I. HIGH FREQUENCY (SEDAC) TESTING AND TREATMENT OF ELEVEN CASES OF PARKINSON'S DISEASE

Case and No.	Age	Sex	Marital Status	Duration of Illness Years	Etiology	Medication Taken During Therapy	Sedac Test Findings	E. E. G. Findings	Symptoms, Findings and Impairment
M.H. (1)	66	F	Mrd.	7	Art. scl.	Artane Benedryl	All areas reduced maximum tolerance and dulled minimum sensitivity.	Dysrhythmia Grade (1) Generalized	4 plus gait, station, rigidity, tremor, movements, vasomotor, pain in left arm.
P.P. (2)	71	M	Mrd.	10	Art. scl.	None	All areas elevated maximum tolerance.	Normal	1-2 plus facies, gait, station, tremor, and movements.
A.S. (3)	59	F	Mrd.	6	Art. scl.	None	Occiput and vertex posterior areas elevated maximum tolerance.	Dysrhythmia Grade (2) Left temporal	1-2 plus gait, station, rigidity, movements, head tremor.
L.V. (4)	61	F	Mrd.	5	Trauma (Head injury)	Hyocine Benzedrine Barbital	Occiput and jaw areas elevated maximum tolerance.	Dysrhythmia Grade (2) Generalized	4 plus fatigue, facies, gait, station, movements, tremor, rigidity, pain extremities, depression.
A.D. (5)	65	M	Mrd.	10	Virus infec. Shingles	Artane	All areas elevated maximum tolerance and ultra minimum sensitivity.	Dysrhythmia Grade (2) Generalized Bitemporal	3-4 plus fatigue, facies, gait, station, rigidity, tremor, vasomotor, oculo-gyric and depression.
T.P. (6)	75	M	Mrd.	11	Previous encephalitis (1918)	Artane	All areas elevated maximum tolerance.	Normal	3 plus fatigue, facies, gait, station, rigidity, tremor movements, speech, oculo-gyric.
S.H. (7)	79	M	Mrd.	6	Art. scl.	Hyocine	All areas elevated maximum tolerance.	Dysrhythmia Grade (1) Bitemporal	4 plus facies, gait, station, rigidity, tremor, movements, vasomotor, speech.
P.P. (8)	67	M	Mrd.	7	Art. scl.	Hyocine Benedryl	All areas elevated maximum tolerance.	Dysrhythmia Grade (2) Bitemporal	3-4 plus gait, station, rigidity, movements, vasomotor, depression.
F.M. (9)	70	F	Mrd.	7	Art. scl.	Barbital	All areas elevated maximum tolerance and dulled min. sens.	Drsyhythmia Grade (2) Generalized	3-4 plus fatigue, gait, station, rigidity, tremor, movements, oculo-gyric. –
W.V. (10)	75	M	Div.	7	Art. scl.	None	All areas elevated max. tol. and ultra min. sensitivities.	Dysrhythmia Grade (1) Generalized Max. L. temp.	2 plus tremor hands, rigidity, movements.
H.W. (11)	59	M	Mrd.	20	Encephalitis following smallpox	Artane Benedryl	All areas elev. max. tol. and dulled min. sens.	Dysrhythmia Grade (1) Generalized	4 plus fatigue, facies, gait, station, rigidity, tremor, movements, pain extrem.

the normal range, the ultrasensitive range, or the more insensitive range of current intensity. An approximation of the "normal" and abnormal sedac unit values (the result of five years of investigation) has been determined and described previously.[14]

This paralysis agitans treatment project was sponsored and assisted in part by a grant-in-aid from the Grace Hospital of Detroit and was conducted during the summer months of 1959 at this institution. All of the patients receiving therapy were referred by their private physicians.

Eleven patients were included in the project. Four were females and seven were males. The etiologic factors varied widely. The duration of the illnesses likewise was quite diverse, varying from five to twenty years, with a mean average of 8.7 years.

Two hundred and seventy treatments were given. The frequency of therapy was twice weekly, and the duration of each treatment varied from fifty to ninety minutes. Each patient was sedac-tested for minimum sensitivities and maximum tolerances initially, midway through therapy and at termination. In addition, each was subjected to history-taking, a neurologic examination and an electroencephalogram.

Table I describes pertinent data concerning each patient. Figures 1-5 are logarithmic graphic presentations of the data for five individual patients. Each graph portrays the minimum sensitivities and the maximum tolerances initially, after twelve treatments and at termination. Vertically and to the left are designated the sedac unit values. Below and horizontally, the legend defines the test-treatment positions and other data.

All patients were treated with different leads. Some were treated monopolar and others, bioplar. This differentiation was determined largely by two factors. The first was based on the abnormal test values of any given area. For example, if the left temporal area and the right occiput area measured abnormal, the two areas were enveloped and treated. On the contrary, if the right parietal area and the vertex anterior area measured within the range of normal, treatment was not applied to these areas. The second factor dealt with comfort and tolerance of treatment proper. If the patient tolerated therapy and progressed more satisfactorily with monopolar rather than bipolar leads (or vice versa) his therapy was given accordingly.

If properly and skillfully given, patients have no fear of sedac therapy. Actually, the therapy gives much comfort. The term *sedac* is used because the high frequency currents possess sedative-like qualities. Most of the patients fall soundly asleep during the entire therapy interval.

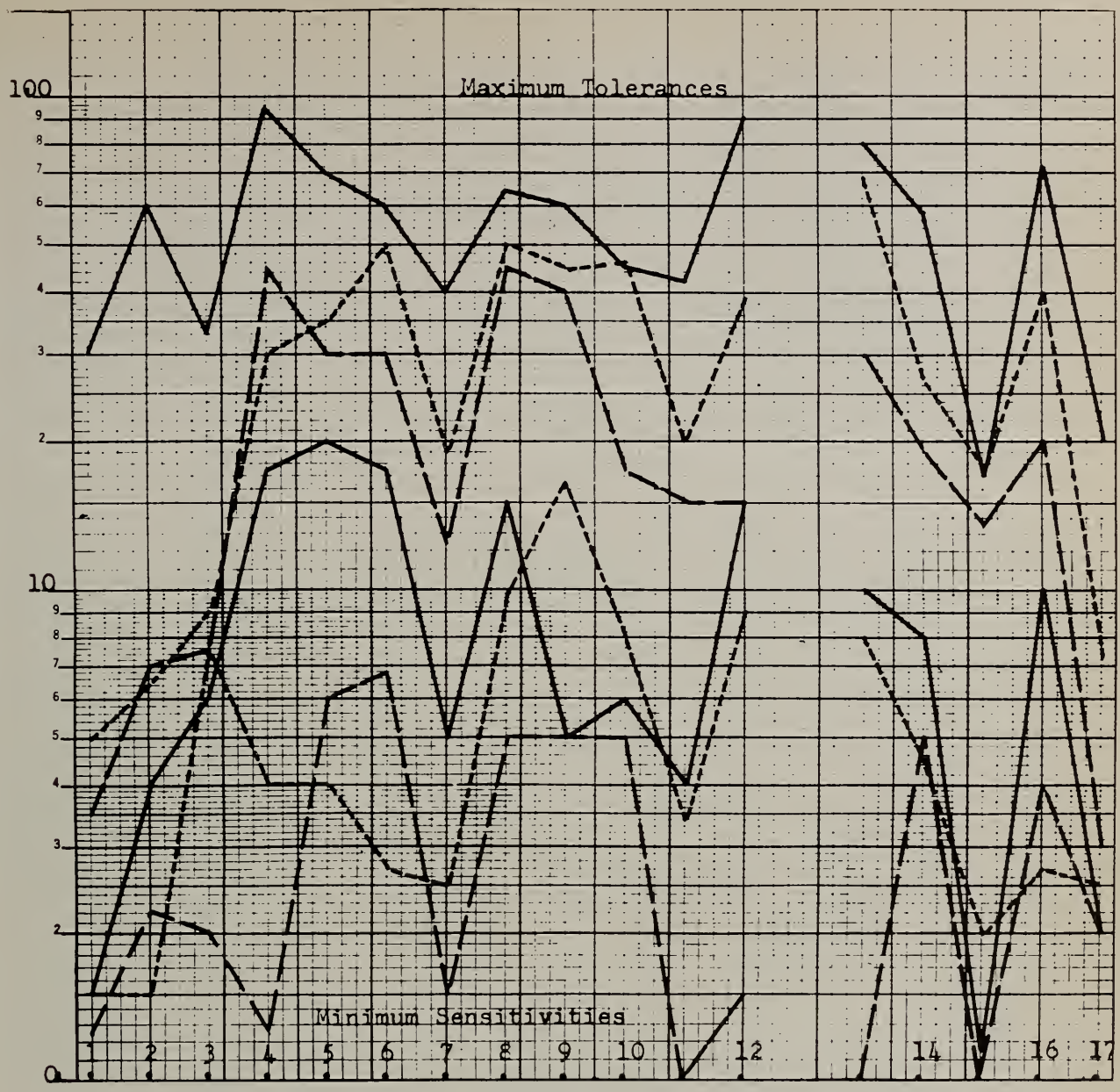


Fig. 1. Case 1. Paralysis agitans syndrome. High frequency (sedac) testing and treatment.

Figs. 1-5. Solid line is initial measurement. Broken line is measurement after thirteen treatments. Dotted line after twenty-six treatments. Monopolar: Indifferent electrode is right forearm. 1. pre front.; 2. vert. ant.; 3. vert. post.; 4. occ. mid.; 5. jaw l.; 6. temp. l.; 7. par. l.; 8. occ. l.; 9. jaw r.; 10. temp. r.; 11. par. r.; 12. occ. r.; Bipolar: 13. jaw l. to r.; 14. temp. l. to r.; 15. par. l. to r.; 16. occ. l. to r.; 17. pre front. to occ. mid.

The criteria of improvement resulting from therapy was based upon the observations and evaluations of the senior author, consultations with relatives or friends of the patient and the statements of the patients, themselves. The phenomena of transference was carefully considered and was not discounted.

Of the eleven patients treated, nine were improved generally, one was slightly improved and one remained unimproved. The improvement in each situation merits comment:

Case 1.—Lessened fatigue, elevated spirits, increased general activity, locomotion improved, ability to tie shoe laces increased.

Case 2.—Generally improved in all spheres, more active, spirits elevated.

Case 3.—Generally improved, lessening of spasm and tremor of head and neck muscles.

Case 4.—Locomotion, general movement and speech improved; tremor lessened; spirits improved; extremity pains relieved.

Case 5.—Elevated spirits, increased mental clarity, five

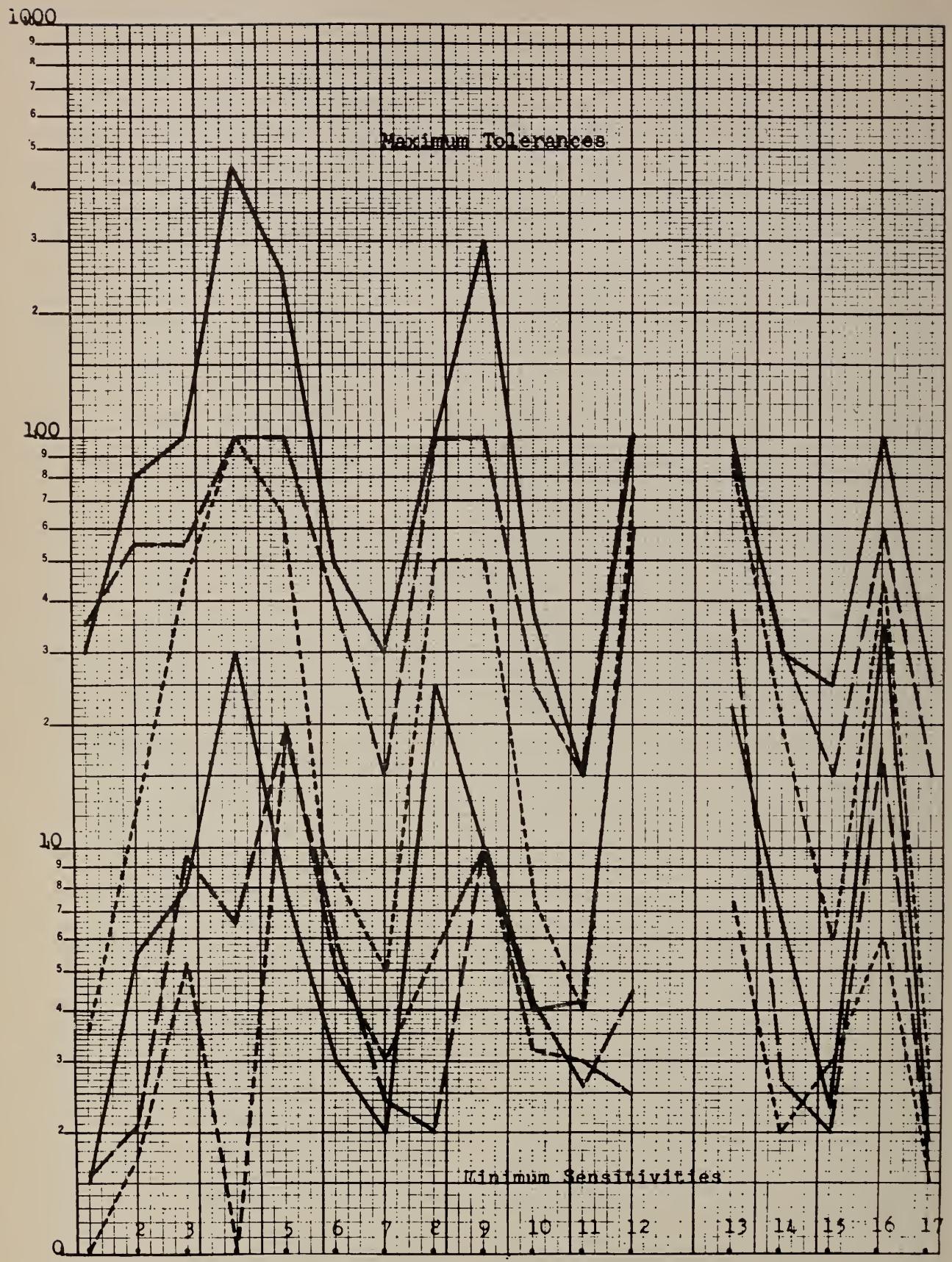


Fig. 2. Case 4. Paralysis agitans syndrome. High frequency (sedac) testing and treatment.

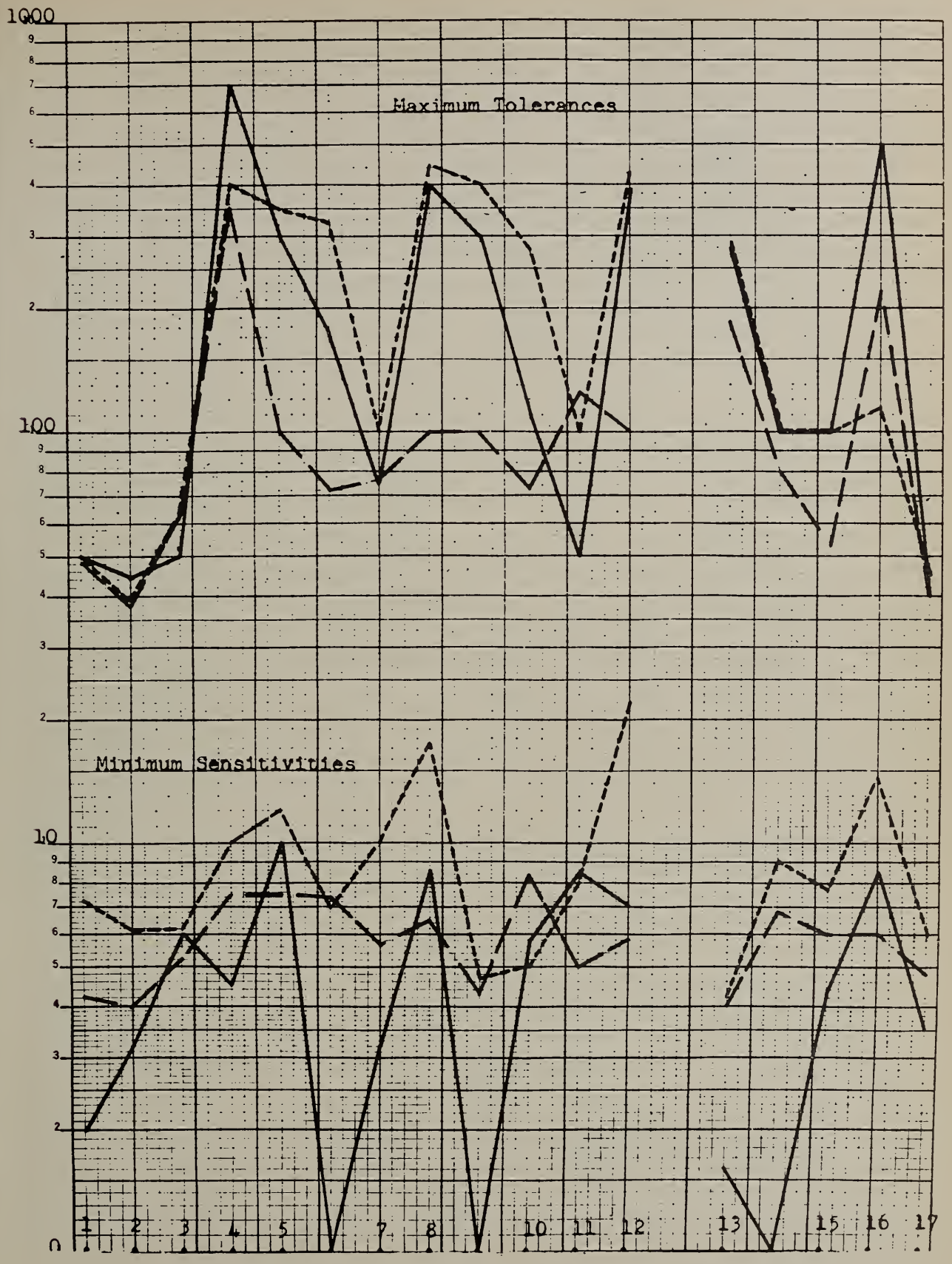


Fig. 3. Case 10. Paralysis agitans syndrome. High frequency (sedac) testing and treatment.

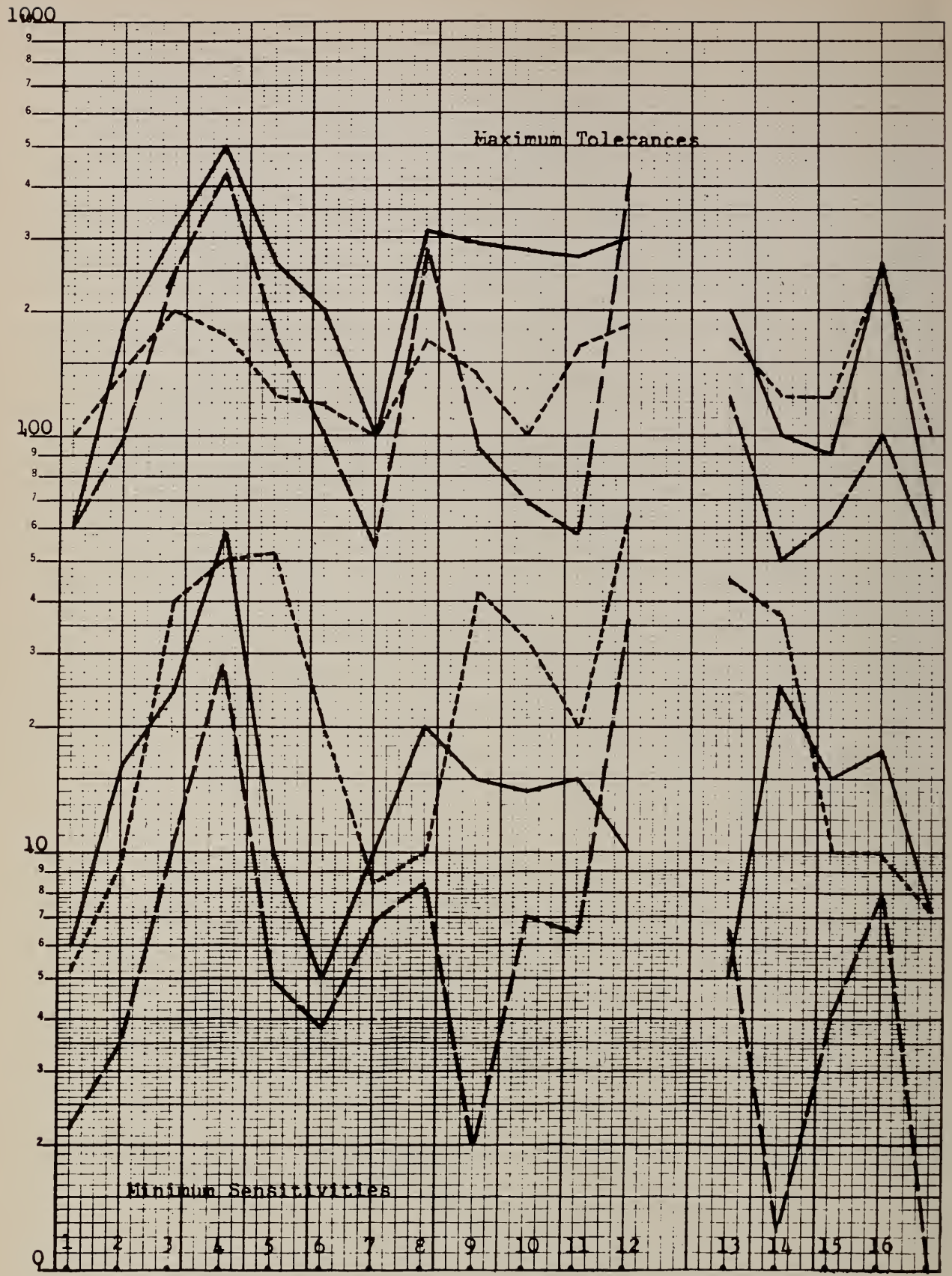


Fig. 4. Case 8. Paralysis agitans syndrome. High frequency (sedac) testing and treatment.

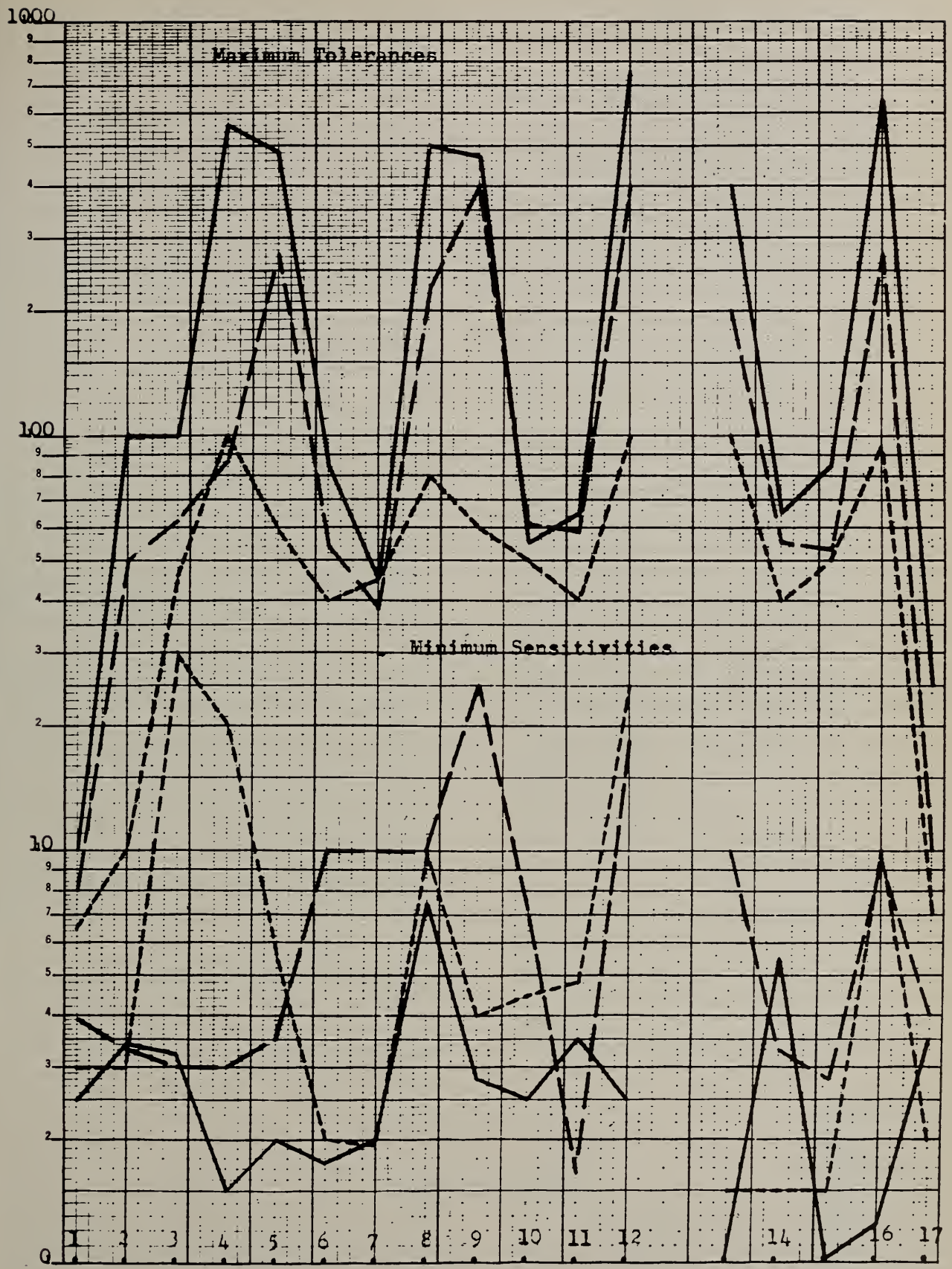


Fig. 5. Case 5. Paralysis agitans syndrome. High frequency (sedac) testing and treatment.

movements improved, patient does odd jobs about house and yard—the first he has done in two years.

Case 6.—Locomotion improved, facial tremor lessened.

Case 7.—Unimproved.

Case 8.—Unimproved except for better spirits.

Case 9.—Spirits improved, mental clarity increased, somewhat more active in household work.

Case 10.—Tremor is much improved; he handles cup, glass and toothbrush better; mental clarity and spirits are up; he is more relaxed and less rigid, walks more easily.

Case 11.—Much improved, has had no falls, spirits and mental clarity are elevated, drooling less, locomotion improved, working on lawn and pulling weeds which he has not done for three years.

The instigation of effective therapy in any organic brain syndrome, whether psychiatric or neurologic or both, is a formidable undertaking. Not only is any therapy frequently discouraging, it becomes quite perplexing as the disease process progresses.

All subjects treated had sustained longstanding deeply ingrained illnesses. At the onset of therapy, effort was made to reduce or discontinue drug medications in all cases. Of the eleven patients, we were successful in removing three from medication, while the electrocerebral therapy was in progress. Parkinson's disease patients are sometimes described as a rather "pill-happy lot." Indeed, they are quite uncomfortable and accustomed to considerable medication intake. During the summer of 1959, Detroit, in particular and the country in general, experienced an extremely hot and humid summer. Frequently, telephone calls were received from the patients asking to resume medication for this reason alone. This may or may not have been a valid reason. At any rate, control of the medication intake itself was difficult and frequently impossible.

It is concluded that, as in certain other chronic brain syndrome disease, the high frequency currents may come to have a place in treatment of paralysis agitans. It is further concluded that, while treatment perhaps need be neither more intense nor more frequent, it should be carried out over a much longer duration of time. Because of many exigencies, this project had to be limited in scope.

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Maternity Statistics

The American public now spends about $1,150,000,000 a year on all types of maternity care—hospitals, physicians' services, et cetera. This figure does not include the value of free maternity care provided by private and governmental sources.

The average maternity patient today makes about 10 prenatal visits to her physician, stays about 4.5 days in a hospital at delivery, and spends $272 for all hospital, medical, and similar services used during her pregnancy.—*Health Information Foundation.*

Atheroma and Thrombosis

Major Threats to Our Health Today

Paul D. White, M.D.
Boston, Massachusetts

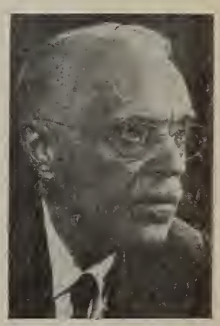
IT is a pleasure to present a summary of my recent thoughts and experiences related to the vital question of atheroma and thrombosis, that is, diseases of the arterial wall which are major threats to our health today.

Atherosclerosis and thrombosis are two different problems unless we accept the thesis that all atherosclerosis is based on previous thrombotic processes as presented by several investigators of the past and particularly of late by Professor Duguid. Similarly, I regard hypertension as an abnormality distinct from atherosclerosis although hypertension undoubtedly is an aggravating factor and marked atherosclerosis in older people can produce systolic hypertension by the establishment of a full pulse pressure due to inelasticity of the major arteries. My current belief is that the chief hazard to our health today is that of the atherosclerosis itself although I quite agree that superimposed thrombosis, blocking any one of a number of vessels such as the coronary, the internal carotid, the renal, or the iliac can have very serious consequences. At least two-thirds of the cases of sudden death encountered by Dr. Milton Helpern during his long experience in the Coroner's Office in New York City showed extensive coronary atherosclerosis with no fresh thrombosis. A minority do show thrombi. In other words, one can die of angina pectoris without an actual fresh occlusion. I shall, therefore, base my remarks today primarily on the atherosclerotic lesion and its clinical significance and have less to say about the complicating or admittedly serious thrombosis that is superimposed. Nor shall I have much of anything to say about the hemorrhages in the coronary intima or atheromatous plaques long ago described as common by Paterson of London, Ontario, and recently confirmed by Helpern and his associates in New York.

I wish to quote at the beginning of this discourse from Shakespeare and later from Lancisi. In *As You Like It*, Act II, Scene VII, Jacques in the forest, where a table is set, speaks as follows in answer to the Duke's statement of—

Thou seest we are not all alone unhappy:
This wide and universal theatre
Presents more woeful pageants than the scene
Wherein we play.

Jac. All the world's a stage,
and all the men and women merely players;
They have their exits and their entrances;
And one man in his time plays many parts,
His acts being seven ages. At first the infant,
Mewling and puking in the nurse's arms,
Then the whining school-boy, with his satchel
And shining morning face, creeping like snail
Unwillingly to school. And then the lover,
Sighing like furnace, with a woeful ballad
Made to his mistress' eyebrow. Then a soldier,
Full of strange oaths, and bearded like the pard,
Jealous in honour, sudden and quick in quarrel,
Seeking the bubble reputation
Even in the cannon's mouth. And then the justice,
In fair round belly with good capon lined,
With eyes severe and beard of formal cut,
Full of wise saws and modern instances;
And so he plays his part. The sixth age shifts
Into the lean and slipper'd pantaloon,
With spectacles on nose and pouch on side,
His youthful hose, well saved, a world too wide
For his shrunk shank; and his big manly voice,
Turning again toward childish treble, pipes
and whistles in his sound. Last scene of all,
That ends this strange eventful history
Is second childishness and mere oblivion,
Sans teeth, sans eyes, sans taste, sans everything.



The Author

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In Shakespeare's day, life was short. Although we know not the actual ages in years to which he assigned these seven periods of life, we may guess that they were short in time. The expectation of life was very limited, probably not much over twenty years, and men and women were already old at forty. In fact, 250 years after Shakespeare, which would be about 100 years ago, a woman died at forty-five in a ward of the Massachusetts General Hospital and the only diagnosis on the record at that time, as I have read myself was "old age." We know now that one does not die of old age. I myself have always found some adequate cause, such as would be noted in younger people, for example, pneumonia, severe coronary atherosclerosis, cerebral vascular lesion, rupture of an abdominal aortic aneuysm, and many other events of the sort. Let me guess that Shakespeare meant that an infant or young child, that is, the first age of man, might extend from birth to the age of five, the second period, that of the whining school boy, from five to fifteen, the third age that of the lover from fifteen to twenty-five, the fourth that of the soldier from twenty-five to thirty-five, the fifth that of the judge, that is, an experienced professional man, from thirty-five to forty-five. Quite likely the judge in his early forties "in fair round belly with good capon lined" had a fair amount of atherosclerosis which may not have allowed him to survive into the sixth and seventh ages. From forty-five to fifty-five we come to the "lean and slipper'd pantaloon," and finally at sixty second childhood. This division of years is a probability, not a certainty.

Today with the great extension of life, including not only the average expectation which is about seventy instead of thirty as in Shakespeare's time and forty (plus or minus) a hundred years ago, we know that many healthy persons are active in the sixties, seventies, and eighties. Rarely is pneumonia any more the old man's friend although a patient of mine, aged 107½, who was quite healthy as to his heart and cerebral condition, unfortunately did die of pneumonia which had threatened to kill him 105 years earlier when he was but an infant.

I would like to paraphrase Shakespeare's seven ages of man by setting up my own subdivision of life, namely five periods of twenty years each, which I feel quite sure might well be our goal perhaps within a generation and, I certainly hope, not much later. I would divide life into five periods of twenty years each, the first from birth to twenty, that of youth. Once upon a time this was the terrible time of life and actors on the stage in these two decades died of infections right and left. Even when I was a medical student and an intern in the hospital and for a few years afterwards, the infant and childhood mortality was very high. Babies, whom I helped to take care of in 1911, died like flies, chiefly of dysentery before the pasteurization of milk. Children died of diphtheria. I myself had it but fortunately was rescued by antitoxin. Smallpox still occurred. My own father almost died of smallpox in 1881 in London and he had typhoid fever three times during his years of family practice. I myself escaped typhoid but it was still so current that our wards were full of it every fall. There was no room in the hospitals for any cardiovascular patient or anybody with cancer. Meningitis, empyema, and mastoiditis were constant emergencies and the toll was frightful. Just to think back on those days is like redreaming a nightmare. The young doctors today cannot imagine what we faced. We had a good deal of malignant endocarditis, that is, subacute bacterial endocarditis, and it was 99 per cent fatal. Tuberculosis led the list in mortality. We didn't have any cholera, to be sure, although my own father's mother had died of it on Bunker Hill in Charlestown in 1860 in her very early twenties when father was still a young infant.

Henry Christian, who was our Professor of Medicine, when I was in medical school, gave his first six lectures in the theory and practice of medicine on typhoid fever practically verbatim from the first chapter of Osler's textbook, the idea being that if we knew this infection we knew medicine. Today the first six lectures might well be given on the theory that if we know atherosclerosis we know medicine, but we certainly hope that a generation from now, this too may be in large part past history, at least in youth and middle age. The challenge is here. There is no reason why, having accomplished what we have in the control of infections, we may not accomplish still more in the control of the current hazards to health which, by the way, include automobile accidents on the road, as well as cancer and cardiovascular disease.

I try to refer nowadays to cardiovascular disease rather than heart disease, underlining the vascular part of the word and emphasizing the fact that most of our serious heart disease is not due to primary heart muscle (myocardial) disease, but rather to vascular disease. This is just as much true of cerebral diseases, diseases of the kidney and other viscera and of the legs. These troubles in major part are due to the same process, atherosclerosis, which affects the intima of all these areas of the circulation. The chief

hazard in the first age period of man today (birth to twenty), as I have outlined, is, so far as I know, that of accidents with infections way down. We haven't abolished them all by any means, but we have gone a long way. Accidents on the road were almost unknown when I was a medical student. It is a ridiculous state of affairs now to allow our young people to slaughter themselves on the roads.

We come now to the second twenty-year period from twenty to forty. These, I call, the critical years today in contrast to those of a generation ago. It is in this period of life when all seems to be going well that atherosclerosis gets going even while the candidates for trouble look so healthy, in fact too healthy, robust, with high color, and symptomless. These are the critical years for countless numbers of males in whom this process of atherosclerosis begins to be laid down. The average male in America settles down at about twenty-five to a life of physical indolence although with often great nervous activity in his profession or business. He has no more time to exercise or to have relaxing recreation of any sort. He has an automobile and can hardly move without it. He has a television set before which he lolls in the evening on return from his office and his wife cooks too well. He puts on a pound or two or three of weight every year during this period and that extra weight is not muscle. When I see him as a patient at the age of forty-five to fifty he is 20 to 30 pounds heavier than he was at twenty-five. I always inquire now of my patients with coronary heart disease at the average age of fifty what their weight was at twenty-five. It is almost invariably true that much weight has been added slowly through the years, though sometimes rapidly during the earlier years soon after marriage. Of course, it isn't the actual fat under the skin to carry around that is important. This probably does not increase the burden on the heart much although it may be uncomfortable when stooping. In fact, it might be good exercise to carry this weight around if there weren't an infiltration into the arterial intima of much of the fat. A few ounces in the wrong place must be very much more harmful than many pounds tucked away under the skin here and there throughout the body. During these decades from twenty to forty there are still infections to guard against, but we no longer have so much the threat of syphilis or so much the recurrence of rheumatic fever from a streptococcus sore throat, or even appendicitis as is evident from a lantern slide that I will quote from shortly. Hypertension may start, perhaps associated with the way of life and quite likely also on a hereditary basis, which is incidentally back of much of our early atherosclerosis.

Then we come to the third age of man from forty to sixty which is the middle period of middle life where much of the disease that has been slowly building up becomes apparent by symptoms, signs, or sudden death. Hypertension, coronary atherosclerosis of high degree giving rise to angina pectoris, sudden death, or heart attacks with myocardial infarction, little strokes and big ones too, abnormalities of the circulation to the legs, and cancer are the chief threats through this period of twenty years. Here is the ripening of the hazard that started in the twenties or thirties. It is quite certain that the health in this period in middle age from forty to sixty is largely dependent on what has happened before, much less in childhood, that is, before twenty, than in the period from twenty to forty. It is quite obvious that we must start a campaign for "middle aged fitness." Most of our efforts have been directed to our youth, and quite rightly, and what has been done for them has been very important. I myself belong to the President's Council for Youth Fitness, but this is only a beginning. Much more important is now a campaign for *middle aged fitness* and I would like to promote this for the sake of improvement in fitness in middle age by the application of the measures about which we know a good deal already, although we haven't as yet all the answers.

The last two periods of life will also be vastly improved by this program and the male will at last have a chance to begin to catch up with the female in expected longevity. At the present time the American male expects to live only to sixty-seven years or a bit more and the female to seventy-three plus. This difference of six years has increased in the last generation largely due to the earlier hazards in middle age, chiefly atherosclerosis which affects the male so far as the coronary arteries are concerned twenty-four times more often than the female under the age of forty, about five times more in the forties, and about twice more in the fifties. We must make every effort to change the present inequality of these ages and the great surplus of widows over widowers in the middle of the *later period of middle age which I would put from sixty to eighty.*

Finally, we come to old age from eighty to 100 which can be much healthier if we can forestall some of the progressive changes in the intima of the coronary and other vital arteries earlier in life and if we can avoid hypertension and some of the other ills, including cancer of course, that strike middle-aged

persons. In addition to the prolongation of life we have the problem of maintaining health, that is, of adding life to years as well as years to life. It is in general true that the longer we can keep people living the more useful they can be. It is absurd to require retirement in the sixties. Most people, especially in the future, will still be very useful in the seventies and well enough to carry on quite vigorously both mentally and physically. There is no reason why a man of seventy to eighty should not continue to shovel snow if he is well, perhaps at not quite so fast a tempo. We might aim for 100 per cent mortality from coronary atherosclerosis if it kills quickly at the age of 100 during the night, while the victim is asleep without any illness or incapacity prior to that time. This would mean the cancellation of the serious infections, of cancer, of accidents, of war, and many other ills. It will be a fine and perchance a final goal.

Now let me quote from a translation of Lancisi's preface and a bit of his second volume on *De Subitaneis Mortibus,* that is, on Sudden Deaths,* a remarkably interesting forecast of what we see and think today.

At Rome, in the summer, autumn and winter of 1705 down to the spring equinox of 1706, were many sudden deaths. The populace as they do in a Panic, invented a number of explanations: the poor quality of the tobacco; exhalations from the earth after recent earthquakes; inferior chocolate, a mysterious poison (virus) in the air. Pope Clement XI turned, as he ought, to spiritual remedies and a special liturgy, but uniting prudence and piety, appointed in January, 1706 a committee of investigation and ordered the head physician of the Medical College at Rome to have some of the bodies dissected. Lancisi was appointed head of the Commission to report to His Holiness; Cardinal Pallavicini, the Governor of Rome, gave all possible assistance and the experiments were made in a public theatre. By means of such dissections and other observations which Lancisi now publishes he arrived at certain conclusions. Meanwhile others have published dissertations in Italian and Latin, meritorious as far as they go, but these men lacked my opportunities. First I shall deal with sudden deaths in general, a subject of late neglected, and in my second volume shall discuss whether this disease was of a universal or a particular, or, as I believe, a mixed type. I shall add some anatomic discussion. May the Reader enjoy it.

So wrote Lancisi* in the preface of his book *De Subitaneis Mortibus* in the year 1707, 252 years ago. He continued discussing possible causes of sudden death along this same vein in Chapter 1 of Book II:

Was the cause simple (not complicated) and universal, or particular and mixed? First, was the cause particular in individual cases? We know that in certain years or seasons, death comes to men, yes and to animals such as cattle and goats, from a pestilential condition of the air or a taint in air or water, or from a scarcity or defect in their pasture, and that it rages without warning. So sang Fracastoro in his golden verses:

> Sometimes tis only beasts that are chastised,
> Many or only some thereof, I do remember
> One summer's baleful heat; an autumn followed
> With soaking rain; the south wind blew continually,
> Then every kind of goat, but of all living things
> The goats alone, did perish.

But I consider it more likely that the cause of the sudden deaths at Rome was not single and absolutely common to all, but that in the majority of cases there was a special cause for each case. I conclude this from the external symptoms, and my conviction was only strengthened by experiments. For it will be shown in the following pages that the peculiar and principal cause of premature death in each case was the presence of certain seeds, which were produced gradually and were finally called into action on a sudden; as Hippocrates says: 'Diseases do not come to men suddenly but are collected and pile up little by little.' No need to blame the tobacco; since some whose nostrils were never defiled by that dust died suddenly. Or exhalations from earthquakes, since many who escaped death lived where there had been most earthquakes. Nor was the chocolate to blame, for men like Dr. Placentius, an octogenarian, or myself, accustomed to drink it as much as twice a day for thirty years either escaped altogether or had only light symptoms. On the other hand, many who never tasted it died suddenly. Nor was it a case of undetected poison in the air, for when like augurs we inspected the entrails, we found clear and well known causes for the disease.

Before the Pope ordered us to dissect, there was evidence for the theory that the cause of death was particular and not universal; in some cases there were symptoms of rupture of the blood carrying canal which had been weakened by a varix or an aneurism in the chest or abdomen. Many died of violent apoplexy due to stoppage or effusion of blood in the brain; others of a violent spasm of the heart or paralysis or obstruction of the passages of the heart and of the large arteries. Thus was hindered the passage of the blood from the heart into the lungs and the brain, and so the vital and reciprocal communication of those organs was suddenly cut off. But I must repeat again and again, that so far as I know, every one of those who died suddenly had long suffered from some disease of the fluids, the intestines, or at least of the blood vessels. . . . Therefore, to the best of my belief, these sudden deaths did not come to the healthy, but nearly always to those who had long suffered from poor health. For them this was a sort of foaming over of human nature, or an unfavorable crisis arose, with men who had long been either openly or secretly in poor health.

These remarkable observations of Lancisi were unfortunately never followed up, otherwise much more

*Translation by Wilmer Cave Wright (unpublished—in manuscript), kindness of New York Academy of Medicine.

interest would have been developed in the evolution of the processes of disease which lead to sudden death, including in particular atherosclerosis which must have been seen although it was not well described either grossly or with the help of the primitive microscopes of the day except in one case report in the second edition of Bonet's Sepulchretus in 1700. It is quite obvious from our experience of late years, as well as occasional notations by the more astute observers like Lancisi, that neither sudden death nor angina pectoris nor coronary thrombosis comes suddenly to a healthy man. The evolution of the process is a slow one, taking years at least and perhaps decades before symptoms or signs develop.

Can we, as seems quite possible, by the newer techniques of angiocardiography and other simpler methods, diagnose serious degrees of atherosclerosis at a much earlier stage than we are now able to identify them? Even if we should do so, much more would have to be done before corrective curative measures might be applied. Therefore, it seems obvious to me, and I am sure to all of you, that our chief effort in research, basic and clinical, must be directed to a more intensive study of the initial processes, physical, chemical, and hereditary in order to learn how we may counteract them.

Our task is two-fold: that of the identification of the candidate for serious trouble early in life or in middle age, with a study not only of the family history but also of characteristics which we have believed to be of some importance, such as body build, and blood chemical findings like hyperglycemia and hypercholesterolemia. Although we should attempt to make some effort to protect the whole population, nevertheless the candidates are the ones we should concentrate on first. Such candidates should be identified if possible in their early years even perhaps in their teens, at any rate not later than their twenties. For such candidates and perhaps for all of us, simple measures may be advisable even now before we have all the proof, such measures as the avoidance of any gain in weight after the age of twenty-five, the reduction of the animal fat content of our very rich American diet, and the institution of programs of regular exercise and relaxation of other sort too with an effort to neutralizing at least somewhat the emotional stress that is so characteristic of current urban life.

If we can also discover in the course of our researches, which is quite possible, magical remedies in the form of chemical substances to counteract hypercholesterolemia and inherited enzyme defects, we may not need to carry out so much the other protective measures even though they seem very reasonable to us now. And while we are busy with our researches on these problems, we should try to correct the erroneous opinions and practices of countless individuals in this country who are still inclined to blame hard work as the primary cause of atherosclerosis and its complications.

Just one word about hard work. It is true that one can get very tired both physically and mentally from hard work, but I have yet to find a man or woman, otherwise healthy, who, from hard work alone, has become ill provided he or she carried out a sensible program of life, avoiding the hazards which I have first mentioned above.

In conclusion, may I express optimism about the future results of our researches, physical, chemical, hereditary, pathological, and clinical on atherosclerosis, especially of the premature varieties. Within another generation, in fact I believe within a decade, with the present increasing tempo of vigorous research, we should have some definitive answers which will allow us to protect our men and to expand increasingly the expectation of a long and healthy life.

Again, as I have frequently done in the past, I would like to end with another quotation from Shakespeare:

> Our remedies oft in ourselves do lie, which we ascribe to Heaven.

Cancer Study Sets Available

The Michigan Cancer Registry has available for loan a group of study sets consisting of histologic slides, chiefly of various types of neoplasms. These sets are available without charge to all interested physicians in Michigan. A deposit is required and this will be refunded subject to deductions for loss or breakage. For further information, write to Director, Michigan Cancer Registry, 4811 John R Street, Detroit 1, Michigan.

Malabsorptive Syndromes

Considerations in Diagnosis And Treatment

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THE FUNCTIONS of the gastrointestinal tract include motility, secretion, digestion, absorption, storage and excretion. All of the other functions are largely ancillary to the basic process of absorption.

Recently much interest has been centered about the physiology of absorption and the defects or dysfunctions responsible for malabsorption.[1,2,3] This increased interest in absorption stems from a number of factors.[4] New methods have become available for the study of absorptive defects. These included the development of a rapid method for the determination of fecal fat, the use of radioiodine labeled "fat," the use of D-xylose for quantitating defects in carbohydrate absorption, the determination of plasma glycine levels after gelatin feeding as a test for pancreatic function and the techniques for obtaining biopsies of the small intestine mucosa safely and relatively simply. Many of these diagnostic techniques have become available in clinical practice. Physicians have become aware of an increased incidence of malabsorptive syndromes. The purpose of this report is to define and classify the malabsorptive syndromes; to review the value and limitations of the various tests of absorptive capacity in terms of reliability, simplicity and availability in clinical practice and to discuss the diagnostic features and treatment of the malabsorptive syndrome.

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Classification

The malabsorptive syndromes are characterized by a group of symptoms which develop when the usual constituents of the diet are not absorbed in the normal manner. Malabsorption may result either in impaired digestion or faulty absorption. Steatorrhea, the excessive fecal excretion of fat, is a prominent part of many malabsorptive syndromes. The absorptive defect may be limited to a single factor, as in pernicious anemia, or may be broad, as in idiopathic steatorrhea.

A number of classifications for the malabsorptive syndrome have been suggested. Adlersberg divided those disorders into primary and secondary malabsorption.[5] Primary malabsorption included celiac disease, tropical and nontropical sprue. The remaining cases of malabsorption were termed secondary malabsorption.

Ruffin and Janssen[6] have emphasized the distinction between impaired digestion with normal absorption and impaired absorption in the presence of normal digestion. A somewhat similar classification has been suggested by Spiro and Friedman.[7]

Volwiler,[8] in a scholarly discussion of the malabsorptive syndromes, suggested a classification based upon the principal biochemical processes involved in fat digestion and absorption which follows:

I. Inadequate mixing of food with bile salts and lipase
 - A. Pyloroplasty
 - B. Subtotal gastrectomy
 - C. Total gastrectomy

II. Inadequate lipolysis—lack of lipase
 - A. Pancreatic insufficiency
 1. Congenital cystic fibrosis of the pancreas
 2. Chronic pancreatitis
 3. Cancer of the pancreas or ampulla
 4. Pancreatic fistula
 5. Protein deficiency

III. Inadequate emulsification of fat—lack of bile salts
 A. Obstructive jaundice
 B. Severe liver disease

IV. Primary absorptive defect—small bowel
 A. Inadequate length of normal surface
 1. Surgical resection
 2. Internal fistula
 B. Obstruction of mesenteric lymphatics
 1. Lymphoma
 2. Carcinoma
 3. Whipple's disease
 4. Tuberculosis
 C. Inadequate absorbing surface due to extensive mucosal disease
 1. Inflammatory
 a. Tuberculosis
 b. Regional enteritis
 2. Neoplastic
 3. Amyloid infiltration
 4. Scleroderma
 D. Biochemical dysfunction of mucosal cells
 1. Celiac disease
 2. Sprue
 3. Severe starvation
 4. Transient dysfunction associated with intestinal infections
 E. Malabsorption associated with blind loops, diverticula, strictures and surgical anastomoses.

Clinical Manifestations

The clinical manifestations of malabsorption can be considered in terms of the responsible pathophysiological mechanisms. Thus, inadequate absorption may result from the following: (1) inadequate biochemical preparation of the ingested material for absorption; (2) an uncontrolled rate of delivery of the nutrients to the small intestinal lumen; (3) lack of adequate time for contact between the nutrients and a normal intestinal surface; (4) biochemical and/or structural defects of mucosal cells of the small intestine; or (5) competition for the use of ingested nutrients by bacteria under circumstances of unusual intestinal disease which allows bacterial overgrowth in stagnant areas of the gastrointestinal tract.

Steatorrhea is the most striking defect accompanying the broad malabsorptive syndrome. However, malabsorption may be present without any gross evidence of steatorrhea. About 85 per cent of patients with steatorrhea have diarrhea.[4,9] Other clinical manifestations include hemorrhagic phenomena, tetany, osteomalacia or osteoporosis, malnutrition, edema, amenorrhea, megaloblastic or iron deficiency anemia, glossitis and cheilosis, and peripheral neuritis.

Loss of calories is the most important single aspect of the broad malabsorptive syndromes. Fat represents the major source of high calorie food in the diet. Defective fat absorption may be manifest by weight loss and malnutrition. Malnutrition leads to depletion of body stores of protein with the development of hypoproteinemia and edema. Protein deficiency results in osteoporosis, pancreatic insufficiency and atrophy of the mucosa of the small intestine. The defect in calcium absorption results in osteomalacia. Iron deficiency anemia, or megaloblastic anemia, or both, may be observed in patients with sprue or celiac disease and in patients following total gastrectomy. Megaloblastic anemia may also follow partial gastrectomy if mucosal atrophy of the remaining stomach is present.[10] A deficiency of vitamin B_{12} and anemia may result from bacterial or parasitic interference with normal absorption of vitamin B_{12}.[11] The same mechanism may be responsible, in part, for the various signs of vitamin deficiency present in patients with sprue.

Absorptive defects, if severe, extend to carbohydrates, electrolytes, water soluble vitamins and water. Peripheral neuritis, glossitis and cheilosis, result from deficiency of the water soluble vitamins. Tetany results from impaired absorption of both vitamin D and calcium. Hemorrhagic phenomena may result from impaired absorption of vitamin K. The ocular and skin changes of vitamin A deficiency may be present.

Special Diagnostic Studies

The diagnostic approach to the patient with malabsorption should begin with a complete history and physical examination. Particular inquiry should be directed to determining the character and frequency of the stools. Although a few patients will have normal bowel habits, most patients with the broad malabsorptive syndrome have diarrhea. Diarrhea may be manifest by an increased frequency of bowel movements, but is always characterized by an increased volume of the stool for twenty-four hours. A history of prior gastrointestinal surgery is important. The presence of abdominal pain and diabetes in conjunction with steatorrhea may suggest pancreatic insufficiency. Fever, abdominal pain and arthritis are suggestive of Whipple's disease.

The physical examination should be complete. Particular attention should be paid to the abdominal findings, signs of vitamin deficiencies or neurologic defects. A positive Trousseau test or spoke wheel cataracts are signs of hypocalcemia. Excessive intraluminal fluid in the small bowel in patients with sprue may cause abdominal distention out of proportion to the degree of tympany.[12]

Certain laboratory examinations are indicated in all patients suspected of having malabsorption. These in-

clude examination of the blood smear for anemia, evidence of macrocytosis or iron deficiency, determination of the prothrombin time and the serum albumin and globulin concentrations. Patients with prolonged steatorrhea should have determinations of the serum calcium, phosphorus and alkaline phosphatase.

A radiologic examination of the small bowel is indicated in all patients with suspected steatorrhea. The classic changes consist of dilatation, segmentation, abnormal motility, the moulage sign and an increase in intraluminal fluid. These changes are typical of patients with sprue,[13] but they may be found to a lesser degree in some of the other malabsorptive syndromes. Some of these abnormalities are related to the nature of the opaque medium used. The excessive mucus, produced in response to the increased amount of fatty acids within the bowel lumen, results in precipitation of the barium sulphate. Chemical abnormalities of gastric and small intestinal mucus in some of the malabsorptive syndromes may also influence the roentgen appearance.

If the stools are bulky, foamy, and foul smelling, the diagnosis of steatorrhea may be suspected upon gross examination of the stool. However, the appearance of the stool yields little information as to the nature and degree of the absorptive defect. Gross examination of the stool, although not to be neglected, may be highly unreliable. It is of value if oil, buttery materials, or egg particles are present. The presence of vegetable fibers, such as corn, has no diagnostic significance. Large numbers of undigested muscle fibers can be readily seen microscopically and are common in patients with pancreatic insufficiency.[14]

Examination of the stools should include the use of acid hydrolysis of the stool, employing Sudan III and a drop of acetic acid. The mixture is heated briefly and then inspected under the microscope. Fat droplets appear as bright orange globules. More than two to three globules per field are indicative of excess fat in the stool. Some estimates as to the percentage of fat in the stool can be obtained by measuring the size of the globules.[15] Globules larger than 75 microns in diameter are indicative of a significant absorptive defect, and globules of 125 microns in diameter are indicative of a rather severe defect. Interpretation of this test is not easy and requires experience.

Steatorrhea can also be suspected from the consistency of the stool when rubbed between the fingers. The buttery materials in the stool impart a slippery, greasy quality.

Fat Absorption.—For precise investigative work, fecal fat balance studies are necessary. Several methods have been employed to measure fecal fat. A wet extraction method can be used.[16,17] Less than 90 per cent of ingested fat on a diet containing 60 gm. daily is abnormal.[18] Calculated diets are not required if more than 50 gm. of fat are ingested per day. Between the ranges of 60 and 150 gm. of fat, neither the quantity nor type of fat influences the quantity of fat excreted in the feces.[19] *More than 6 gm. of fat in the stool per day when a patient is on a normal diet is indicative of steatorrhea.* The stools should be collected for at least three days, and preferably longer.

A small quantity of fat is present in the stools of experimental subjects who are on a fat free diet.[4] Most of this fat is contributed by the rapidly desquamating epithelium of the small bowel,[8,20] although some may be contributed by secretion of fatty complexes from the blood into the lumen of the bowel.[21] Intestinal bacteria may synthesize fat under abnormal circumstances.

The weight of the stool is useful in determining the presence or absence of steatorrhea. The normal stool should weigh less than 200 gm. per twenty-four hours; stools from patients with absorptive defects usually weigh much more.

Although it is agreed that the fat balance technique is the most reliable approach for the quantitative assessment of steatorrhea, other simpler screening procedures have been proposed. Nile blue added to oleates in the presence of NA_2CO_3 results in a blue color. The Nile blue reaction correlates reasonably well with the degree of fat present in the stool determined by chemical analysis.[22]

After ingestion of vitamin A, the vitamin A level of blood of normal individuals increases rapidly. The vitamin A tolerance is a simple method for measuring rate of absorption of fatty materials. Low fasting vitamin A levels may be observed in patients with liver disease, and severe hepatic damage is often associated with a flat vitamin A tolerance curve. However, a flat vitamin A tolerance curve is usually indicative of impaired absorption, although flat curves may be found in normal patients. The test is of little value in quantitating the degree of steatorrhea in patients after gastrectomy.[23] Despite these limitations, the absorption of Vitamin A from an oily medium tends to parallel the degree of fat absorption as measured by fat balance studies,[18] and has been found to be of value as a screening test for steatorrhea.

The plasma carotene of fasting patients is also useful as a screening test for steatorrhea.[24] This determination is simpler than the vitamin A tolerance test, but has the same limitations as the former test, namely, it is of little value in patients with post-gastrectomy steatorrhea, or liver disease. The mean normal value is 123 gamma. Determinations between 30 and 70 micrograms are evidence of moderate depletion of carotene stores, and values below 30 micrograms are indicative of severe depletion. A carotene tolerance test has been proposed, which appears to avoid the problem of overlapping of the fasting values between normal subjects and patients with malabsorption. After administration of 15,000 units of carotene orally, three times a day for three days, no overlap was observed in the carotene values between the normal and steatorrheic subjects.[25] The rise in carotene values in normal subjects was always more than 45 gamma; in patients with steatorrhea it was always less than 29 gamma.[25]

Radioiodine labelled triolein and oleic acid have been used in the study of fat absorption. Triolein is an 18 carbon neutral fat possessing one double bond. The radioiodine is firmly attached to this bond and is not split off within the lumen of the intestine.

Lugol's solution is administered prior to the administration of the labelled fat. Blood radioactivity is measured at three, five and seven hours. The stools are collected for three to five days. This technique measures the rate of fat absorption and is affected by the rate of gastric evacuation[26,27] and the nature of the accompanying meal.[27] Ruffin et al,[28] using labelled triolein in a 48 per cent peanut oil emulsion, considered an average of 8 per cent in the three blood samples as normal. The rapidity of absorption is dependent to a considerable degree on the nature of the accompanying meal. The administration of radioiodine labelled triolein in milk results in higher blood levels, more rapid absorption and is less likely to produce nausea and gastric retention than the use of triolein in the 48 per cent peanut oil emulsion.[27]

The differential in absorption between triolein and oleic acid is useful in the diagnosis of pancreatic insufficiency. In this clinical situation the absorption of triolein is impaired while oleic acid is absorbed normally.

If one depends solely on blood levels, one measures the rate of absorption rather than the actual amount of fat absorbed. As with the vitamin A tolerance test, a poorer correlation exists between the degree of steatorrhea as measured by fecal fat excretion and radioiodine labelled triolein in patients with regional enteritis and following gastrectomy.[4,23] Further, the finding of normal blood levels of radioactivity does not exclude the existence of steatorrhea[29,30] A good correlation does exist between the levels of fecal radioactivity during a seventy-two-hour collection period and fecal fat excretion as measured by chemical means. The normal values of fecal radioactivity vary from 0-4 per cent with a mean of 2.5 per cent.

Comparative studies indicate that use of radioiodine labelled fat is a valid method.[31,32] The addition of some indicator substance to the stool is of value. Both blood and fecal levels should be measured. Fecal levels are the more important of the two. However, abnormally high fecal values may result in contamination of the stool specimen with urine containing the iodine label. Abnormally low values may result from gastric retention or motor disorders affecting the small bowel, which result in retention of the labelled fat within the intestine beyond the collection period.

Some investigators have used the urinary I^{131} excretion as an index of the degree of absorption of the labelled fat, and recently, measurement of urinary iodine following Lipiodol ingestion has been suggested as a screening test for absorptive disorders.

Another isotopic technique utilizes vitamin B_{12} labelled with radiocobalt. Intestinal absorption can be measured by the fecal excretion test, the urinary flushing technique, measurement of hepatic uptake, and determination of radio-activity of the serum following oral administration of the labelled vitamin. Impaired absorption has been observed in patients with tropical sprue, sprue in relapse, patients with total and subtotal gastrectomy, pernicious anemia, regional enteritis, and patients with agammaglobulinemia and cystic fibrosis of the pancreas.

Intestinal absorption can also be studied by measuring the radioactivity of expired air sixty minutes after administration of radiocarbon labelled octonoic acid or trioctonate. The radioactivity is decreased for both substances in patients with sprue.[4] Patients with pancreatic insufficiency have normal values following administration of octonoic acid, but decreased radioactivity following administration of trioctonate.

Carbohydrate Absorption.—The D-xylose tolerance test is the most useful parameter for assessing carbohydrate absorption.[33,34] D-xylose is apparently passively and actively absorbed and is not metabolized except for a small fraction. Measurement of the urinary excretion for five hours following administra-

tion of 25 gm. of D-xylose orally is usually employed. Normally, more than 5 gm. of the D-xylose are recovered in the urine during this period. Patients without absorptive defects beyond the age of sixty-five may have urinary values in the abnormal range (2.9 gm.).[35] Low values are obtained in patients with renal disease and congestive heart failure despite normal intestinal absorption. Decreased urinary excretion secondary to malabsorption is observed in patients with sprue, regional enteritis, following partial gastrectomy or loss of absorptive surface, in the presence of multiple small diverticula of the jejunum, and in patients with the Zollinger-Ellison syndrome. D-xylose excretion is usually normal in patients with pancreatic insufficiency.

Protein Absorption.—Daily fecal nitrogen determined by nitrogen balance technique varies between 1.2 and 1.7 gm.[36] Marked azotorrhea is present in patients with diffuse pancreatic disease and nontropical sprue. A five-fold increase in plasma glycine in 2.5 hours can be demonstrated in normal subjects following oral administration of gelatin.[4] Patients with cystic fibrosis of the pancreas have less than a 2.5-fold increase in fasting levels during this same time period.

Diagnosis of Pancreatic Insufficiency.—The diagnosis of pancreatic insufficiency presents many problems. The most reliable method utilizes measurement of the output of the pancreas into the duodenum during a control period and following administration of secretin and pancreozymin.[37,38] Serum trypsin levels have been reported to be elevated in the presence of pancreatic disease. We have been unable to confirm the value of this test. Although serum leucine aminopeptidase has been reported to be elevated in patients with carcinoma of the pancreas, the more recent reports[39,40] have questioned the specificity of this test.

Morphologic Diagnosis.—Transoral small bowel biopsies are of real value in diagnosis.[41] This technique is excellent for the verification of the diagnosis of nontropical sprue, celiac disease and Whipple's disease. The diagnosis of Whipple's disease may also be made by biopsy of involved peripheral lymph nodes or other tissues.

Morphologic confirmation of the clinical diagnosis also can be obtained at exploratory laparotomy. Laparotomy is indicated in patients with suspected pancreatic disease and the blind loop, stricture or massive diverticula syndrome.

Malabsorption Syndromes

The primary malabsorptive syndromes are decreasing in frequency. Whereas sprue was relatively frequent thirty years ago, it is now infrequent. On the other hand, the secondary malabsorptive syndromes are being recognized more frequently. Common causes include: malabsorption secondary to gastrointestinal surgery or loss of absorptive surface; diffuse pancreatic disease; regional enteritis and enterocolitis; and hepatobiliary disease. Uncommon causes of the secondary malabsorptive syndromes include: lymphoma, Hodgkin's disease and tuberculosis; Whipple's disease; scleroderma and amyloid disease; the intestinal fistula, blind loop and massive small intestinal diverticula syndrome; the Zollinger-Ellison syndrome; the carcinoid syndrome; extensive pneumatosis cystoides intestinalis; radiation injury; Henock-Schoenlein purpura; agammaglobulinemia; pseudohypoparathyroidism; diabetic neuropathy, and steatorrhea following neomycin administration or administration of large doses of antacids.

Primary Malabsorptive Snydromes.—Diarrhea, wasting, abdominal distress, segmentation of barium sulphate in the small bowel on roentgen study, absence of postabsorptive systemic hyperlipemia, a low serum carotene, a flat carbohydrate tolerance curve, anemia and signs of vitamin deficiency are characteristic of this syndrome. Although tropical sprue, nontropical sprue and celiac disease may be varieties of the same metabolic disorder, not all students are in agreement.[4]

Sprue is thought to be a genetically determined metabolic disorder. Its manifestations may appear at any period of life.

The initial clinical symptoms of patients with celiac disease usually occur between the ages of the 6th and 24th months. The clinical features of patients with celiac disease may wax and wane. These patients have evidence of absorptive defects even when they are able to tolerate normal diets. Approximately one-half of patients with idiopathic steatorrhea have evidence of having had celiac disease in childhood.[42]

Although a disturbance in bowel habits is present in about 80 per cent of patients with idiopathic steatorrhea, frank diarrhea is present in only about half of the patients. The stools are paler than normal, bulky, offensive and sometimes frothy. Accompanying symptoms include flatulence and indigestion. The appetite may vary from excessive to poor.

The clinical features of patients with tropical sprue vary somewhat from those presented by patients with

nontropical sprue. Tropical sprue tends to occur in epidemic outbreaks, at specific seasons of the year, and in people living under the same environmental conditions.

Characteristic abnormalities in the small intestinal mucosa have been demonstrated in patients with nontropical sprue.[43] The villi are shortened and club shaped. Goblet cells are increased, and the muscularis is infiltrated by inflammatory cells.[43]

Fecal fat excretion in patients with sprue is proportional to the amount of fat ingested. Fats containing large quantities of long chain fatty acids are less well tolerated in diets containing short chain fatty acids. The absorptive defects in sprue affect virtually all food substances.

The D-xylose tolerance test and the serum carotene determination are useful screening procedures. The pattern on roentgen study of the small bowel is characteristic in 70 per cent of patients.[13]

Many patients with sprue achieve virtually complete relief from their signs and symptoms when treated with a gluten free diet.[44] Intolerance to gluten is a major factor in the pathogenesis of celiac disease. The mechanism of the gluten induced enteropathy remains unclear. Further, return of the intestinal mucosa to normal following prolonged use of the gluten free diet has not been convincingly demonstrated.

The gluten-gliadin free diet excludes all cereals except corn and rice. Foods which contain wheat, rye, barley and oats in any form must be excluded. The foods omitted and allowed on the gluten-gliadin free diet have been listed elsewhere.[4]

Adrenal steroids are useful in patients refractory to the gluten-gliadin free diet. The possible complications relating to long term steroid therapy should be kept in mind. Vitamins and minerals should be administered as required. Tropical sprue usually responds well to administration of folic acid and to vitamin B_{12}

Malabsorption Secondary to Gastrointestinal Surgery or Loss of Absorptive Surface.—The absorptive defects of iatrogenic origin are the most common, although they are frequently not of sufficient magnitude to prevent good nutrition if the food intake is adequate.

Steatorrhea is a constant accompaniment of total or near total gastrectomy; fat absorption varies between 30 and 70 per cent.[45] Patients with Hoffmeister 70 per cent resection without vagotomy had a mean fat absorption of 79.9 per cent.[46] Increasing the extent of the resection from 70 to 75 per cent decreases fat absorption to 71 per cent. Removal of 85 per cent of the stomach resulted in fat absorption of 61 per cent. Fecal fat losses are less following the Billroth I resection than following the Billroth II resection.[47]

Part of the decrease in absorption following gastric resection with a gastrojejunostomy or gastroenterostomy is accounted for by lack of stimulation of the pancreas. Partially digested breakdown products of foods, which bypass the pancreas in the Billroth II procedure, represent the major stimulus for pancreatic secretion. Improvement in nutrition can be obtained by frequent small feedings and supplementation with potent pancreatic replacement therapy (Viokase* and Cotazym**).

Resection of a significant portion of the small bowel constitutes a less common but more serious cause of malabsorption. The degree of steatorrhea is directly proportional to the amount of small bowel removed. Diarrhea, significant weight loss and vomiting are common. The stools contain undigested food particles. The diagnosis can be made on roentgen study. The same symptoms and clinical signs follow the inadvertent performance of a gastroileostomy. A similar sequence of events occurs in patients with gastroenterocolic fistula.

Carbohydrate absorption is essentially normal in patients with three or more feet of small bowel. However, approximately 25 per cent of the ingested protein is lost in the stool, and the fat defect is more serious.[4]

Prolonged steroid administration may be of value in treatment.

Diffuse Pancreatic Disease.—Absorptive defects are almost always present in patients with diffuse pancreatic disease. When pancreatic juice is permanently excluded from the duodenum of experimental animals, the stools increase in size and contain excessive amounts of fat and nitrogen. Functional abnormalities of pancreatic secretion account, in part, for the steatorrhea which follows gastric surgery and in patients with diabetic diarrhea.

Cystic fibrosis of the pancreas occurs in children but is an uncommon cause for steatorrhea in adults. Formerly, most of the children died before they reached the twentieth year. The use of antibiotics and potent pancreatic enzyme supplements has en-

*Viobin Corp., Monticello, Illinois.
**Organon, Inc., West Orange, New Jersey.

abled some of these children to live into adulthood. The sweat electrolyte test is positive in patients with cystic fibrosis of the pancreas. The increase in the chloride ion in the sweat can be detected by the use of Fibros paper.†

Establishing that steatorrhea is of pancreatic origin depends upon demonstrating virtual absence of proteolytic and lipolytic enzymes in the duodenal juice, a positive secretin and pancreozymin test and improvement of fecal excretion of dietary fat and nitrogen following administration of potent pancreatic supplements (Viokase or Cotazym). The differential absorption between labelled oleic acid and triolein also is of value in diagnosis. The gelatin film test is of little value because of the presence of fecal bacteria capable of digesting the gelatin. Exploratory laparotomy may be necessary to establish diagnosis of chronic pancreatitis and to rule out the presence of pancreatic carcinoma.

Treatment for pancreatic insufficiency has been greatly improved with the availability of potent pancreatic supplements. Viokase is administered in dosage of 4 to 8 gm. per day. The medication is more effective if the daily dose is divided into hourly increments. The dose of Cotazym varies between 8-12,000 units daily given in divided doses of four to six capsules. Clinical improvement is manifested by control of steatorrhea, gain in weight and a feeling of well-being.

Regional Enteritis and Enterocolitis.—Steatorrhea occurs in patients with extensive enteritis and enterocolitis.[4,20,48] The absorptive defect may not be recognized from gross inspection of the stool. The roentgen findings are of value in establishing the diagnosis. Abnormalities in absorption may be demonstrated for fats and carbohydrates. If a fistula develops between the involved small bowel and the colon, the absorptive defect becomes more severe.

Management is directed primarily to the enteritis, e.g., use of Azulfidine§ and adrenal steroids.

Liver and Biliary Disease.—Absorptive defects develop secondary to severe liver disease and during the course of prolonged obstructive jaundice. Fecal fat studies (chemical or isotopic) are necessary to quantitate the degree of steatorrhea. Tolerance tests yield misleading information.

If the malabsorption is the result of a fistula or chronic obstruction of the biliary tree, surgical treatment should be recommended. Calcium and the fat soluble vitamins should be provided in adequate amounts.

Uncommon Causes of Malabsorption.—*Lymphoma, Hodgkin's disease, carcinoma* and *tuberculosis* result in occlusion of the mesenteric lymphatics. A sprue-like syndrome which does not respond to a gluten free diet and without characteristic biopsy findings of Whipple's disease should raise the question of the presence of a lymphoma or some other neoplasm.

Intestinal tuberculosis has largely disappeared from areas where pasteurized milk is in common use. Surgical resection of the involved area may add to their absorptive difficulty. However, resection of a small stricture in this area may be curative.

More than 200 cases of *Whipple's disease* have been described in this country during the past fifty years. This disorder is characterizer by abdominal pain, fever, steatorrhea, malnutrition, and arthritis. Pancreatic function is normal. The roentgen studies are fairly characteristic.

All of the manifestations observed in the malabsorptive syndromes may be observed in patients with Whipple's disease. Although favorable, clinical and biochemical remissions have accompanied the use of prolonged adrenal steroid therapy, the ultimate prognosis remains poor. A few patients have had prolonged remissions without the use of steroids.

Infiltrative diseases, such as *scleroderma* and *amyloid disease,* may result in steatorrhea. The roentgen alterations accompanying scleroderma include dilatation of the small intestine. Similar roentgen findings have been observed in patients with amyloid disease. The diagnosis of both these conditions usually depends upon obtaining a positive biopsy. The treatment is that of the primary disease.

Steatorrhea may be found in patients with *small intestinal fistula, the blind loop syndrome, massive small intestinal diverticulosis* and *lateral anastomosis of the small bowel.* Vitamin deficiencies and megaloblastic anemia are common. An alteration in the fecal flora may contribute to the clinical features. Oxytetracycline therapy temporarily abolishes the steatorrhea. Surgical removal of the fistula, blind loop or intestinal diverticula is curative.

Patients with the *Zollinger-Ellison syndrome* may have steatorrhea. This is thought to be related to an alteration in the flora of the upper small bowel as a

†Consolidated Laboratories, Inc., Chicago Heights, Illinois.
§Pharmacia Laboratories, Inc., New York.

result of the excess gastric acid secretion. Correction of the hypersecretion results in improved absorption.

The hypermotility of the small bowel in patients with *carcinoid tumors* may result in absorptive defects. A sprue-like syndrome also has been reported secondary to extensive submucosal *pneumatosis cystoides intestinalis* in which gas filled cysts are found in the small bowel. The diagnosis may be suspected on roentgen study.

Transient malabsorption accompanies *radiation therapy* to the abdomen. If the changes are extensive a permanent absorptive defect may occur.

Absorptive defects can occur in patients with *purpura*. The rotentgen findings resemble those accompanying regional enteritis. Abnormalities of the mucosa have been demonstrated on small bowel biopsy. Malabsorption has also been observed in patients with *agammaglobulinemia* and *pseudohypoparathyroidism*.

An experimental form of the malabsorption syndrome has been produced in patients who are given 12 gm. of *Neomycin* daily. These patients have steatorrhea. Cessation of Neomycin therapy results in cure of the steatorrhea and return of their abnormal absorption test to normal. Large doses of *antacids* may also result in a modest degree of steatorrhea.

Summary

Absorption is the basic function of the gastrointestinal tract. Despite recent intensive study, many of the factors concerned with absorption remain poorly understood.

With the availability of new diagnostic techniques, an increased incidence and variety of malabsorptive disorders has been recognized. The clinical manifestations may be variable. Diarrhea is present about 85 per cent of the time. The stool is usually increased in volume. Other manifestations include hemorrhagic phenomena, tetany, osteomalacia and/or osteoporosis, malnutrition, edema, amenorrhea, megaloblastic or iron deficiency anemia, glossitis and cheilosis and peripheral neuritis. The most striking absorptive defect accompanying the broad spectrum malabsorptive syndromes is steatorrhea.

Special diagnostic studies include roentgen study of the small bowel, gross examination of the stool, fat balance techniques, use of radioiodine labelled fats, the serum carotene and carotene tolerance tests, the D-xylose test, pancreatic and liver function tests and transoral biopsy of the small intestine. The value and limitations of these tests are discussed in terms of reliability, simplicity and availability in clinical practice.

The primary malabsorptive syndromes (celiac disease and sprue) are decreasing in frequency. The role of the gluten-free diet and adrenal corticosteroids in treatment is discussed.

The secondary malabsorptive syndromes are being recognized more frequently. Common causes include: malabsorption secondary to gastrointestinal surgery or loss of absorptive surface; diffuse pancreatic disease; regional enteritis or enterocolitis and hepatobiliary disease. Uncommon causes include: lymphoma, Hodgkin's disease and tuberculosis; Whipple's disease; scleroderma and amyloid disease; fistula, blind loop and massive small intestinal diverticula syndromes; the Zollinger-Ellison syndrome; the carcinoid syndrome; extensive pneumatosis cystoides intestinalis; radiation injury; Henock-Schoenlein purpura; pseudohypoparathyroidism and malabsorption following administration of large doses of Neomycin and antacids.

The diagnostic features and treatment of these disorders are discussed. Particular attention is paid to the role of pancreatic insufficiency and its treatment with two potent pancreatic extracts (Viokase and Cotazym).

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Medicine in the Balance

MANY ARTICLES are appearing in magazines, especially in the newspapers, regarding the increasing cost of medical care—which is a term they use when they mean the increasing costs of health care.

It is claimed that the pre-payment plans are pricing themselves out of existence and doctors are blamed for this situation. In the recent request for rate adjustment, the Insurance Commissioner called attention to the fact that the health plans were being priced out of reach and that the doctors *must do* something about it. He mentioned abuses and extra utilization among other things and suggested that the medical profession must have a bigger percentage of doctors participating and then enforce the participation rules. We wish to make a few comments.

IN THE FIRST PLACE, the doctors as individuals are in a very small measure responsible for the increased health care and costs. We are responsible for the extended life expectancy, the many new and better procedures and facilities for saving and prolonging life. We are responsible for the development of the Blue Shield program which started a whole new era of health care for our public. These plans were intended to be full coverage for the patients within the income limits specified, at first $2,500, later extended to $5,000 and $2,500, and finally $7,500, $5,000 and $2,500. Doctors who participated agreed that the services would be rendered as fully paid within those rate limits but where the patient's family was over income the doctor had a right to charge extra up to his customary fee.

This is an old story, but the Michigan State Medical Society and the Blue Shield Board urged all doctors taking care of people outside these income limits, to discuss fees with the family or the patient, agreeing upon the charges to be made if over MMS income limits. That was and is a perfectly logical thing to do and a great many of the doctors do so. Difficulties developed when such an understanding was not arrived at—when extra bills came to patients who anticipated full coverage, they were disappointed and naturally so.

At the special session of the House of Delegates in Lansing, April 16, the House divided into seven discussion groups, each devoting three hours to topics in their general fields; each reported back to the House for final consideration before adjournment. One section discussed quite extensively the item mentioned in this editorial, calling attention to the urgency for doctors to discuss charges with the family in cases where they are over income. This should be done, not only with Blue Shield but with all cases, then the family cannot complain afterwards that they were over charged. This is one complaint being made of the profession quite generally, especially by labor and bureaucrats.

We know that doctors hesitate to discuss prices or charges with

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their patients but the times have reached a condition now where this is completely necessary, otherwise we are open to the increasingly popular slurs being made upon the profession. For our own protection we should have these understandings with our patients.

Deductible Policies

For several years, deductible policies have been available both in Blue Cross and Blue Shield. Unfortunately, industry was not particularly interested unless all of the employees used the same policy and there were not too many groups wishing only the deductible program. This has been a criticism given to the MMS Board and to various others by enormous numbers of critics, including doctors, who claim the establishment of the deductible policy would solve all our problems.

The MMS Board recently passed a resolution that in all negotiations for Blue Shield coverage, the subscribers be given the option of taking the comprehensive contract or the deductible type. This has been noticed generally in the newspapers and we have mentioned it in THE JOURNAL. The Insurance Commissioner insisted that deductible be stressed as another item in the controls he seeks over Blue Shield administration. There is much discussion as to which is ultimately the most economical or the most suitable.

Deductible policies seem to be, in a measure at least, more saleable. Automobile insurance companies have found that they could not exist on a full coverage policy, and you cannot buy one. The Blue Shield program must investigate that phase of administration and determine for itself, the same as it has determined for itself the feasibility of insuring medical care.

Diagnostic Studies

Diagnosis is another item which has caused discontent and serious complaint and has been discussed numerous times at hospital staff meetings and other places. When caring for their patients, doctors should carry on investigations, examinations, laboratory procedures, et cetera, which are necessary to give him sufficient data upon which to make a diagnosis and outline a course of procedure. A complete study is a laudable and very proper procedure, however in many cases it has been abused.

Some doctors order laboratory and other examinations too profusely and some times unnecessarily for the proper and adequate care of their patients. It should be remembered that somebody somewhere must pay for all these services—they are not free. The hospital must charge them to the patient or to Blue Shield, Blue Cross or other insurance, else the hospital is left holding the bag and with an inadequate income.

How to control this service has become a problem. Years ago, Blue Shield brought the matter to the State Medical Society, believing it was a medical administrative problem. Hospital staffs were asked to be on the lookout. This problem is now before us again and the most important stimulus is the very fact that so many groups, bureaucrats, the Insurance Commissioner, comment upon the prepayment services pricing themselves out of existence. This is one item which our members could very easily bring into play with very favorable results. This also was considered at the special MSMS House of Delegates meeting.

As for medical service, in all its forms, pricing itself out of reach, every other service is doing the same. Plumbers, painters, secretaries, bureaucrats, government—all costs are increasing at about 3 per cent a year. The people need Blue Shield—they will pay for it, recognizing it as a necessary cost.

Michigan Clinical Institute

On March 8-10 of this year, Michigan held its Fifteenth Annual Clinical Institute, and we were very much impressed with its extensive coverage, with the investigations of new methods, new materials and new procedures. The program was carried through without a hitch. This included many notable papers, panel discussions and a very outstanding closed television presentation. There was a cancer conference one noon in which outlines were given of research programs and problems that are now being carried on, how and where they are being done and some comments upon the findings and the anticipated findings in the not too distant future.

The first evening was devoted to a discussion of hypnosis in medicine. The chairman was R. W. Waggoner, M.D., of Ann Arbor, and the whole subject was thoroughly investigated. Martin T. Orne, M.D., Boston, told about "Research in Hypnosis," and Louis J. West, M.D., Oklahoma City, talked about "The Use and Value of Hypnosis," both illustrated with motion pictures. Harold Rosen, M.D., Baltimore, discussed "Pitfalls," and the program was followed by a very well-attended and active question-and-answer period. The topic was thoroughly explored, its advantages outlined and its dangers and pitfalls stressed. No one should use hypnosis without a thorough grounding in psychiatry as well as other phases of medicine.

The second evening program under the chairmanship of A. Hazen Price, M.D., Detroit, offered a panel on "Considerations of Nursing Home Care of the Older Patient." Many points were brought out and the impression was that this is a topic demanding more and more attention and immediately. We have the know-how and will be able to care for the aging population satisfactorily if allowed to do so. A panel discussion featured "The Psychiatrist's Viewpoint of Patient Care," presented by Jack Weinberg, M.D., Chicago; Alexander H. Hirschfeld, M.D., Detroit, and Raymond W. Waggoner, M.D., Ann Arbor. This was a very searching discussion stimulating in the extent to which modern medicine is investigating all the types of human frailty. It was followed by half a dozen renowned speakers who were in the audience.

We have always believed that the dominant leaders of the medical profession have ability and a keen impulse to search into almost any area where knowledge is lacking and find leadership which will produce solutions of almost any problem which may be placed before the group. This has happened in the past—it will happen in the future. The amazing thing to witness is how rapidly these topics are being successfully investigated and the promise of the future.

The Blue Shield Number

This is the thirteenth time the June number of THE JOURNAL of the Michigan State Medical Society has been specifically dedicated to Michigan Medical Service with special articles and reports and a special cover design.

The June 1949 cover pictured Robert Novy, M.D., former Michigan Medical Service president, receiving a citation from the National Blue Shield Commission, certifying that Michigan was the first Blue Shield plan to reach a membership of one million persons. General Hawley, executive secretary of Blue Cross and Blue Shield at that time, presented the plaque, and Jay Ketchum, then MMS administrative director, and Howard Shriver, M.D., president of the National Association of Blue Shield Plans, were observers. Since that time, each June has been especially dedicated to Michigan Medical Service with special material and a significant cover design. Michigan Blue Shield was first memorialized with special attention other than news items, reports and editorials, with the December 1947 number, "Blue Cross a Public Trust." (At that time, the term "Blue Shield" had not yet been generalized—both organizations were being called "Blue Cross.")

That issue reported a conference with Senator Arthur Vandenberg, in which he, in the course of an all-day session with a group of administrative officers, told us that our organization was a public trust—that without our intention we had made it so. As such, we owed reports and services to the public. At that time, he said Michigan Medical Service had taken $50 million from the public and had spent it in benefit of their health. During twenty-one years, Blue Shield has been carrying out its function, paying for medical services to subscribers and expended almost half a billion dollars. Right now, payments are in excess of $8 million a month.

Strange to say, the bureaucrats and the socializers have very shrewdly left medicine out of the King-Anderson-Kennedy Bill (HR 4222). The administration is claiming this cannot be socialized medicine because medicine and surgery are not included. If the Social Security program is breeched and this burden of care is put upon it, only very slight amendments may include not only hospital and nursing service and old-age home services, but medical service and surgery and everything doctors do in caring for their patients.

We are very happy to dedicate this number to our Blue Shield program, which in times past, Senator Vandenberg told us, saved medicine from socialized medicine and demonstrated that services could be given to our public without compulsory federal intervention. The Blue Cross and the Blue Shield, in large measure, may again be the salvation of our system of private practice of medicine. It can be, if our membership will cooperate and make it work; otherwise, our advisors tell us socialized medicine is only one step in the future.

We are happy again to present Michigan's Blue Shield.

Kerr-Mills Act vs the King-Anderson Bill

At the special meeting of the House of Delegates of the Michigan State Medical Society, April 16, most of the discussion and action taken pertained to these two bills. The House of Delegates, in its action, and The Council, following through on April 19, urged that each member of the Society familiarize himself with these two pieces of legislation. We have discussed both of them on previous occasions.

The King-Anderson Bill (HR 4222) and (S 909) is the one now in Congress which the administration says is not socialized medicine, but which the medical profession contends, if enacted, would be socialized medicine as far as the bureaucrats and the social planners

wish to make it. It provides a deductible hospital service for every beneficiary of Social Security. The patient must pay $10 per day for the first nine days with a minimum of two days, after which the government pays the rest of the hospital bill up to ninety days. No medical service or surgical service is included. Diagnostic service is included after the patient pays the first $20. The patient can stay ninety days in the hospital, then may go to a nursing home or a convalescent home for another 120 days. A second entrance into the hospital is a new case. The amounts charged and the regulations for the hospitals must be approved by the head of the department (HEW).

The Kerr-Mills Bill was passed by the Federal Congress in the interim session between the nominations and the elections last year after much conference with the AMA, Blue Shield and other organizations. It provides that persons over sixty-five in limited incomes (under $1,500) may receive services through the State Departments of Social Welfare, the Federal government paying half of this bill. This takes care of between 3 and 4 million people on the relief rolls, whether or not on Social Security. Approximately half the states have enacted coordinating laws, and the services are in effect now. HR 4222, if passed, would not go into effect until July 1962.

In Michigan, the Kerr-Mills Bill provides service corresponding with Blue Cross-Blue Shield coverages, but administered under the Department of Social Welfare. The plan provides care for the needy aging people through general taxation which is assessed to everybody rather than through a special tax applied only to the lower income group up to $4,800 at the present time.

The medical profession believed that it had done a constructive service in sponsoring and offering this help for the needy aging people, rather than overloading social security with "socialized medicine." We were happy. However, a discussion at the MSMS Council meeting indicates there is an area in Michigan where the Kerr-Mills Bill cannot be used. Such patients cannot be placed in the Detroit hospitals because payments are only 70 per cent of costs and because the State of Michigan is in arrears $16.5 million for care for its people. The hospitals, in self defense, are not accepting these patients. Members of the medical profession should use whatever influence they have to place Michigan back on a solvent basis and to pay these bills so hospitals and the doctors can render care to the aging. The difficulty seems to be primarily in the Wayne County area—Too bad! It prevents Kerr-Mills benefits to patients in the Detroit District. This section of the membership in the Michigan State Medical Society feel aggrieved and justly so. We owe them some relief.

Responsibility Assigned

The continued turmoil over Blue Shield since the M-75 policies were brought out is causing certain facts to boil to the surface. They are well discussed in the editorials composed by Dr. Haughey.

It is an anomalous situation in which responsibility for increased costs, caused by increased utilization which was invited by expanded benefits should be placed on those rendering the service. Surely, the actuaries bear some responsibility. When the premiums were set, they already had had a warning when we were told many years ago that a $6,000 policy could not be sold for a price the public would be willing to pay.

If pre-payment plans are pricing themselves out of the market, the experience should serve to point up the rapid rise in costs of any social scheme—government sponsored plans especially—and this gives rise to the ever distasteful expedient of control.

Blue Shield was improperly sold under the old plans. It was bought and treated as an indemnity. Neither the public nor the doctors quite realized that this was so. Then came the readjustment to the guaranteed income limit. People have a right to receive the care represented to them as available under these plans. Doctors have a right to participate or not, as their circumstances dictate.

Controls are onerous to doctors and patient alike. The extension of service available under the present policies represents the better medical care which is our goal, and American physicians have stood out firmly for their right to practice unrestricted by the oppressive restraints of arbitrary rules, laws and committee action. We find it distasteful that repeatedly the doctors are told they must do something about utilization. And we find it a bit impractical for doctors eternally to be expected to advise about fee.

Many will not agree, but this writer finds it virtually impossible to estimate the cost of an illness. Freed of economic restraints, the cost will always rise. Diagnostic procedures will always be more extensive

(Continued on Page 808)

Michigan State Medical Society

The Ninety-Sixth Annual Session



H. J. Meier, M.D.
Coldwater
Council Chairman



K. H. Johnson, M.D.
Lansing
President



J. J. Lightbody, M.D.
Detroit
Speaker



D. Bruce Wiley, M.D.
Utica
Secretary

OFFICIAL CALL

The Michigan State Medical Society will convene in Annual Session in Grand Rapids, Michigan. September 24-25-26-27-28-29, 1961. The provisions of the Constitution and Bylaws and the Official Program will govern the deliberations.

Kenneth H. Johnson, M.D.
President
H. J. Meier, M.D.
Council Chairman
J. J. Lightbody, M.D.
Speaker
H. F. Falls, M.D.
Vice Speaker

Attest:
D. Bruce Wiley, M.D., *Secretary*



H. F. Falls, M.D.
Ann Arbor
Vice Speaker

THREE-DAY SESSION OF HOUSE OF DELEGATES

September 24-25-26, 1961

First Meeting—Sunday, 8:00 p.m.

The 1961 House of Delegates of the Michigan State Medical Society will hold a three-day session beginning Sunday, September 24, at 8:00 p.m. The business of the House of Delegates will be transacted in the Ballroom of the Pantlind Hotel, Grand Rapids.

The House will meet also on Monday, September 25 at 9:00 a.m. and 8:00 p.m. and on Tuesday, September 26, at 9:00 a.m. and at 8:00 p.m.

The intervals between meetings of the House of Delegates have been spaced to permit the Reference Committees ample time to transact all business referred to them.

SEATING OF DELEGATES

"A Delegate once seated shall remain a Delegate throughout the entire session and for one year thereafter until the next Session of this House of Delegates, and his place shall not be taken by any other Delegate or Alternate, provided that in case of emergency the House of Delegates may seat a duly accredited Alternate from his component County Society. Any Delegate-Elect not present to be seated at the hour of call of the first meeting may be replaced by the accredited Alternate next on the list as certified by the Secretary of the component County Society involved."—MSMS Bylaws, Chapter 9, Section 6.

Michigan State Medical Society

The Ninety-Sixth Annual Session

PANTLIND HOTEL, GRAND RAPIDS
SEPTEMBER 24-25-26-27-28-29, 1961

INFORMATION

- **GRAND RAPIDS WILL BE HOST TO MSMS IN SEPTEMBER, 1961.**
- **MSMS HOUSE OF DELEGATES** convenes Sunday, September 24, at 8:00 p.m. the Ballroom, Pantlind Hotel. It will also hold two meetings on Monday, September 25 and two on Tuesday, September 26.
- **THE PROGRAM OF THE ASSEMBLY** for the 96th Annual Session of the Michigan State Medical Society lists guest speakers from all parts of the United States. They are the usual stars in the medical world who always grace the podium at annual conventions of the Michigan State Medical Society; they insure a valuable concentrated refresher course in all phases of medicine and surgery for the busy practitioners of Michigan, neighboring states, and the Province of Ontario.
- **DATES OF SCIENTIFIC ASSEMBLY:** Wednesday through Friday, September 27-29, 1961.
- **REGISTRATION FOR SCIENTIFIC SESSION:** Tuesday, 10:00 a.m. (September 26) through Friday noon (September 29), Civic Auditorium. Present your State Medical Society, American Medical, or Canadian Medical Association membership card to expedite registration.
- **NO REGISTRATION FEE FOR STATE MEDICAL SOCIETY AND CMA MEMBERS.** Doctors of Medicine, who are not members of their state medical society or the Canadian Medical Association, will be accorded the privileges of the MSMS Annual Session upon payment of a $25.00 registration fee.
- **REGISTER AS SOON AS YOU ARRIVE. ADMISSION BY BADGE ONLY.**
- **MEMBERS OF MICHIGAN MEDICAL SERVICE** will meet in annual session, Tuesday, September 26, at 2:00 p.m. This meeting will follow the annual MMS luncheon which will be held in the Ballroom of the Pantlind Hotel.
- **ALL SUBJECTS** at the MSMS Annual Session are applicable to clinical medicine. They stress diagnosis and treatment, usable in everyday practice.
- **POSTGRADUATE CREDITS** given to every MSMS member who attends MSMS Annual Session.
- **FIVE ASSEMBLIES**—16 Section Meetings—all on September 27-28-29.
- **PAPERS WILL BEGIN AND END ON TIME.** The MSMS scientific meeting always features by-the-clock promptness and regularity.

ANNUAL SESSION APPOINTMENTS

Chairman of Arrangements
H. G. Benjamin, M.D., Grand Rapids

House of Delegates News Committee
J. J. Lightbody, M.D., Detroit, Chairman
H. F. Falls, M.D., Ann Arbor
C. Allen Payne, M.D., Grand Rapids
D. Bruce Wiley, M.D., Utica

Scientific News Committee
H. G. Benjamin, M.D., Grand Rapids, Chairman
F. S. Alfenito, Jr., M.D., Grand Rapids
F. C. Brace, M.D., Grand Rapids
J. A. Ferguson, M.D., Grand Rapids
A. B. Gwinn, M.D., Hastings
P. W. Kniskern, M.D., Grand Rapids
C. L. Weston, M.D., Owosso

Scientific Exhibits Committee
Joseph R. Lantini, M.D., Chairman

- **TECHNICAL AND SCIENTIFIC EXHIBITS** will contain much that is new and scientifically educational. Two daily intermissions to view the exhibits have been arranged.
- **STATE SOCIETY DINNER DANCE,** Thursday, September 28, in the Ballroom of the Pantlind Hotel, Grand Rapids at 7:00 p.m., reception—dinner—dancing. All MSMS members and their ladies are invited to the State Society Dinner Dance for an evening of fun and merriment. Join the group for preprandials, followed by dinner, dancing, a highly amusing talk by our own Homer H. Stryker, M.D., of Kalamazoo, and a stellar floor show. It's all for you and your lady!

SCIENTIFIC ASSEMBLY

Wednesday-Thursday-Friday
September 27-28-29, 1961

SAVE AN ORDER FOR THE EXHIBITORS AT THE MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION

Michigan State Medical Society

Ninety-Sixth Annual Session

HOUSE OF DELEGATES

PANTLIND HOTEL, GRAND RAPIDS, SEPTEMBER 24-25-26, 1961

ORDER OF BUSINESS*

SUNDAY, SEPTEMBER 25, 1961

Ballroom, Pantlind Hotel, Grand Rapids

6:00 p.m.—Registration

8:00 p.m.—First Meeting

1. Call to Order by Speaker
2. Report of Committee on Credentials
3. Roll Call
4. Prayer—R. Wallace Teed, M.D., Ann Arbor
5. Appointment of Reference Committees
 - (a) On Officers' Reports
 - (b) On Reports of The Council
 - (c) On Reports of Standing Committees
 - (d) On Reports of Special Committees
 - (e) On Constitution and Bylaws
 - (f) On Resolutions
 - (g) On Special Memberships
 - (h) On Rules and Order of Business
 - (i) On Legislation and Public Relations
 - (j) On Hygiene and Public Health
 - (k) On Medical Service and Prepayment Insurance
 - (l) On Miscellaneous Business
 - (m) On Executive Session
 - (n) On National Defense and Disaster Planning
6. Speaker's Remarks—J. J. Lightbody, M.D., Detroit
7. President's Remarks—Kenneth H. Johnson, M.D., Lansing
8. President-Elect's Remarks—Otto K. Engelke, M.D., Ann Arbor
9. Annual and Supplemental Reports of The Council —H. J. Meier, M.D., Coldwater, Chairman of The Council
10. Report of Delegates to American Medical Association—W. A. Hyland, M.D., Grand Rapids, Chairman
11. Brief of Annual Report of Woman's Auxiliary—Mrs. Paul Ivkovich, Reed City
12. Brief of Annual Report of Michigan State Medical Assistants Society—Mrs. Betty Lou Willey, Port Huron
13. Report on Michigan Medical Service

MONDAY, SEPTEMBER 25, 1961

Ballroom, Pantlind Hotel, Grand Rapids

9:00 a.m.—Second Meeting

14. Supplemental Report of Committee on Credentials
15. Roll Call
16. Awards:
 - (a) Selection of Michigan's Foremost Family Physicion
 - (b) Fifty-year Awards
17. Resolutions†
18. Reports of Committees of the House of Delegates
 - (A) Permanent Advisory Comimttee on Fees
 - (B) Committee to Review Constitution and Bylaws
 - (C) Committee to Study Problem of Malpractice
 - (D) Committee to Study the Problem of Indigent Doctors of Medicine
19. Reports of
 1. MSMS Standing Comimttees
 - (A) Committee on Postgraduate Medical Education
 - (B) Public Health Committee
 - (1) Committee on Rheumatic Fever Control
 - (2) Committee on Maternal Health
 - (3) Committee on Venereal Disease Control
 - (4) Committee on Tuberculosis Control
 - (5) Committee on Occupational Medicine
 - (6) Committee on Mental Health
 - (7) Committee on Child Welfare
 - (8) Committee on Geriatrics
 - (9) Cancer Control Committee
 - (10) Committee on Blood Banks
 - (11) Committee on Diabetes
 - (12) Iodized Salt Committee
 - (13) Committee on Rural Medical Service
 - (C) Committee on Ethics
 - (D) Committee on Legal Affairs
 - (E) Committee on Mediation
 - (F) Committee on Public Relations (and Subcommittees)
 2. MSMS Special Committees
 - (A) Advisory Committee to Michigan State Medical Assistants Society
 - (B) Advisory Committee to Woman's Auxiliary
 - (C) Medical Care Study Committee
 - (D) Scientific Radio Committee
 - (E) Study on Prevention of Highway Accidents Committee

MONDAY, SEPTEMBER 25, 1961

Ballroom, Pantlind Hotel, Grand Rapids

8:00 p.m.—Third Meeting

20. Supplemental Report of Committee on Credentials
21. Roll Call
22. Unfinished Business

*See the Constitution, Articles IV, VII, and XII, and the Bylaws, Chapter 9 on "House of Delegates."

†All resolutions, special reports, and new business shall be presented in writing in triplicate (Bylaws, Chapter 9, Section 10-m).

23. New Business
24. Reports of Reference Committees
 (a) On Officers' Reports
 (b) On Reports of The Council
 (c) On Reports of Standing Committees
 (d) On Reports of Special Committees
 (e) On Constitution and Bylaws
 (f) On Resolutions
 (g) On Special Memberships
 (h) On Rules and Order of Business
 (i) On Legislation and Public Relations
 (j) On Hygiene and Public Health
 (k) On Medical Service and Prepayment Insurance
 (l) On Miscellaneous Business
 (m) On Executive Session
 (n) On National Defense and Disaster Planning

TUESDAY, SEPTEMBER 26, 1961

Ballroom, Pantlind Hotel, Grand Rapids

9:00 a.m.—Fourth Meeting

25. Supplemental Report of Committee on Credentials
26. Roll Call
27. Unfinished Business
28. New Business
29. Supplemental Reports of Reference Committees

TUESDAY, SEPTEMBER 26, 1961

Ballroom, Pantlind Hotel, Grand Rapids

8:00 p.m.—Fifth Meeting

30. Supplemental Report of Committee on Credentials
31. Roll Call
32. Unfinished Business
33. Supplemental Report of The Council
34. Supplemental Reports of Reference Committees
35. Elections
 (a) Councilors
 1st District—A. E. Schiller, M.D., Detroit—Incumbent
 4th District—Wm. A. Scott, M.D., Kalamazoo—Incumbent
 5th District—C. Allen Payne, M.D., Grand Rapids—Incumbent
 6th District—H. H. Hiscock, M.D., Flint—Incumbent
 (b) Delegates to American Medical Association
 J. S. DeTar, M.D., Milan—Incumbent
 W. A. Hyland, M.D., E. Grand Rapids—Incumbent
 O. J. Johnson, M.D., Bay City—Incumbent
 C. I. Owen, M.D., Detroit—Incumbent
 (c) Alternate Delegates to American Medical Association
 W. W. Babcock, M.D., Detroit—Incumbent
 G. B. Saltonstall, M.D., Charlevoix—Incumbent
 J. M. Wellman, M.D., Lansing—Incumbent
 B. M. Harris, M.D., Ypsilanti—Incumbent
 (d) President-Elect
 (e) Speaker of the House of Delegates
 (f) Vice Speaker of the House of Delegates
36. Adjournment

MICHIGAN MEDICAL SERVICE MEMBERS' SCHEDULE

(Coincident with MSMS House of Delegates)
Pantlind Hotel, Grand Rapids

Tuesday, September 26, 1961

12:30 p.m.—Reception, Kent State Room

1:00 p.m.—Luncheon, Kent State Room

2:00 p.m.—MMS Annual Meeting, Ballroom

All MSMS Delegates are members of Michigan Medical Service corporation and are expected to attend the MMS Luncheon and Annual Meeting. The MMS Annual Meeting is open to ALL members of the medical profession, who are cordially invited to attend.

HOTEL RESERVATIONS MICHIGAN STATE MEDICAL SOCIETY

96th Annual Session

Grand Rapids, September 27-28-29, 1961

The reservation blank below is for your convenience in making your hotel reservations in Grand Rapids. Please send your application to the Committee on Hotels for MSMS Convention, Pantlind Hotel, Grand Rapids, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Committee on Hotels by sharing a room with another registrant, when convenient.

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Committee on Hotels,
Michigan State Medical Society
c/o Jack Ament, Room Reservation Manager
Pantlind Hotel, Grand Rapids, Michigan

Please make hotel reservation(s) as indicated below:

———— Single Room(s) ————persons

———— Double Room(s) for ————persons

———— Twin-Bedded Room(s) for ————persons

Arriving September ———hour———A.M.———P.M.

Leaving ————————hour———A.M.———P.M.

Hotel of First Choice: ————————————

Second Choice: ————————————

Names and Addresses of all applicants including persons making reservations:

Name	*Address*	*City*	*State*

Date ———— Signature ————————

Address ———————— City ————

MSMS HOUSE OF DELEGATES, 1961
Delegates and Alternates

(Names of Alternates appear in italics)

OFFICERS

J. J. Lightbody, M.D., 501 David Whitney Bldg., Detroit
Speaker

Harold F. Falls, M.D., 1313 E. Ann St., Ann Arbor
Vice Speaker

D. Bruce Wiley, M.D., 8090 Clinton River Rd., Utica
Secretary

Milton A. Darling, M.D., 673 Fisher Bldg., Detroit
Immediate Past President

A. Verne Wenger, M.D., 132 Grand Ave. S.E., Grand Rapids
Honorary Member

ALLEGAN

Lewis F. Brown, M.D., 133 E. Allegan St., Otsego
James I. Clark, M.D., Box B, Fennville

ALPENA-ALCONA-PRESQUE ISLE

John W. Bunting, M.D., 110 N. First St., Alpena
Edward A. Hier, M.D., 125 N. Second Ave., Alpena

BARRY

Alexander B. Gwinn, M.D., 102 E. State St., Hastings
Everett L. Phelps, M.D., 118 E. Walnut St., Hastings

BAY-ARENAC-IOSCO

David A. Bowman, M.D., 101 W. John St., Bay City
Stanley A. Cosens, M.D., 101 W. John St., Bay City
Wm. G. Gamble, Jr., M.D., 2010 5th Ave., Bay City
Edward R. Rodda, M.D., 101 W. John, Bay City

BERRIEN

Noel J. Hershey, M.D., P.O. Box 222, Niles
Paul O. Rague, M.D., 960 Agard, Benton Harbor
F. Alan Kennedy, M.D., 239 Pipestone, Benton Harbor
Fredk. H. Lindenfeld, M.D., 8 North St. Joseph Ave., Niles

BRANCH

Robert M. Leitch, M.D., 304 N. Broadway, Union City
Robert J. Fraser, M.D., 22 Pearl St., Coldwater

CALHOUN

Harvey C. Hansen, M.D., 65 W. Michigan Ave., Battle Creek
Keith S. Wemmer, M.D., 1472 W. Michigan Ave., Battle Creek
Chas. J. Ryan, M.D., Leila Post Hospital, Battle Creek
Salvatore A. Yannitelli, M.D., 1331 W. Michigan, Battle Creek

CASS

Uriah M. Adams, M.D., Marcellus
Sherman L. Loupee, M.D., 110 W. Division St., Dowagiac, Mich.

CHIPPEWA-MACKINAC

Donald D. Finlayson, M.D., 301 E. Spruce St., Sault Ste. Marie
Earl S. Rhind, M.D., 300 Court St., Sault Ste. Marie

CLINTON

Franklin W. Smith, M.D., 105 S. Ottawa, St. Johns
J. M. Grost, M.D., 110 Oakland St., St. Johns

DELTA-SCHOOLCRAFT

Francis C. Anderson, M.D., 218 South 10th St., Escanaba
Harold Q. Groos, M.D., 1015 South 1st Ave., Escanaba

DICKINSON-IRON

Donald R. Smith, M.D., Box 471, Iron Mountain
Donald T. Anderson, M.D., 408 Hamilton Ave., Kingsford

EATON

Byron P. Brown, M.D., 339 S. Cochran, Charlotte
Robert E. Landick, Jr., M.D., 111 S. Cochran St., Charlotte

GENESEE

Frank D. Johnson, M.D., 653 S. Saginaw, Flint
John E. Wentworth, M.D., 1651 Chevrolet Ave., Flint
Wm. F. Buchanan, M.D., 238 W. Caroline St., Fenton
Clifford W. Colwell, M.D., 328 S. Saginaw, Flint
J. Leonidas Leach, M.D., 3007 Industrial Ave., Flint
Lawrence G. Bateman, M.D., 1928 Lewis St., Flint
David McTaggart, M.D., 312 Paterson Bldg., Flint
John M. Schwartz, M.D., 1300 N. Dort Hwy., Flint
Thomas N. Eickhorst, M.D., 1604 Mott Foundation Bldg., Flint
John Quin, Jr., M.D., 2765 Flushing Rd., Flint
Ernest P. Griffin, Jr., M.D., 621 Mott Foundation Bldg., Flint
Harry V. Sparks, M.D., 2765 Flushing Rd., Flint

GOGEBIC

Wayne A. Gingrich, M.D., 109 E. Aurora St., Ironwood
John R. Franck, Jr., M.D., 401 Sunday Lake, Wakefield

GRAND TRAVERSE-LEELANAU-BENZIE

Frank H. Power, M.D., 116 Cass St., Traverse City
Charles E. Lemen, M.D., 110 S. Madison, Traverse City

GRATIOT-ISABELLA-CLARE

John M. Wood, M.D., 314 S Brown, Mt. Pleasant
D. K. Barstow, M.D., 215 W. Saginaw, St. Louis

HILLSDALE

Arthur W. Strom, M.D., 32 S. Broad St., Hillsdale
Luther W. Day, M.D., Grosvener Bank Bldg., Jonesville

HOUGHTON-BARAGA-KEWEENAW

Andrew M. Roche, M.D., 221 5th St., Calumet
Leonard C. Aldrich, M.D., 301 Quincy St., Hancock

HURON

Charles W. Oakes, M.D., Harbor Beach
Charles F. Wible, M.D., Sebewaing

INGHAM

Lawrence A. Drolett, M.D., 3526 W. Saginaw St., Lansing
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Responsibility Assigned

(Continued from Page 800)

when the cost is paid than when the patient pays the whole freight. It would be fatuous to believe otherwise.

But whereas, in the government-supported hospitals, this has always been so without arousing comment, we see the doctors under Blue Shield submitted to insult and calumny for imitating the finer practices they saw as students and read about in their periodicals.

Nor can we quite agree that the doctors should eternally be apologists for Blue Shield. Traditionally and rightfully, it is the company which explains the provisions of its policies. "Read your policy" is an age-old admonition printed on the paper of commercial companies.

Let the doctor order what the patient needs. Let him be little concerned with the type of insurance the patient carries. For any service which is not covered under that policy which the patient carries, let the company make the point clear, if it has not done so at the time the policy was sold, and the patient will know where his responsibility lies.

Before the Code of Ethics was abridged, it read in part:

> "Poverty—should command the gratuitous services of a physician. Institutions—for sickness and life insurance, or for analogous purposes, should meet such costs as are covered by the contract under which the service is rendered."

The contract belongs to the patient. It was issued by the company. The apologetics do not belong with the doctor.

Louis J. Bailey, M.D.
Assistant Editor

Wayne State Advances Medical Center Plans

Plans are progressing for the new Wayne State University "Medical Center" in the heart of Detroit. The multi-million dollar plan provides for the redevelopment of an area bounded by Woodward, Mack, Hastings and Ferry. The 236-acre site is adjacent to the Cultural Center and Wayne State.

The major feature of the development is the affiliation of Wayne State's College of Medicine with Woman's, Children's, Grace and Harper Hospitals and the Rehabilitation Institute.

Clarence B. Hilberry, WSU president, has revealed that the first building will be placed just north and east of Harper and Grace Hospitals.

* * *

"THE LOCATION OF THE medical college in the center of the whole area is symbolic of the role it is destined to play in the coordinated operation," Dr. Hilberry said. He noted that the hospitals and the Institute have a total of over 2,000 beds "which will provide an ideal research and teaching center."

"These, combined with the resources of the Detroit Receiving Hospital, will give the College of Medicine resources which are unexcelled," President Hilberry stressed.

"The arrangements which have been concluded with the hospitals make it unnecessary for the university to plan for a university-owned and operated hospital for its teaching and research programs," he added.

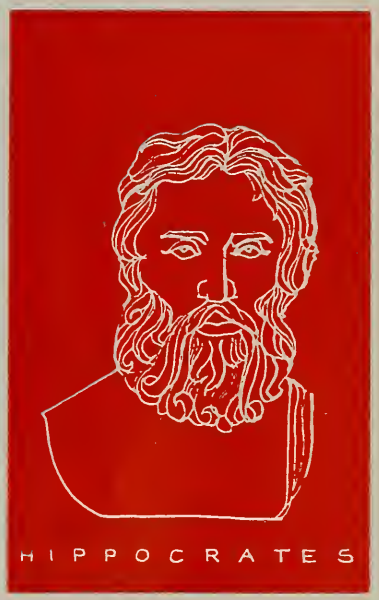
The Metropolitan Detroit Building Fund is including in its current campaign $2,300,000 for land costs and $1,840,000 to help provide a new building for Children's Hospital. Last year the Legislature authorized $2,250,000 for a Medical Research Building and granted $250,000 to prepare the plans. The Research Construction Commission of the National Institutes of Health has allocated an additional $1,692,000 for matching funds for this building. The gift makes possible the erection of a structure which will have approximately 130,000 square feet of space and will cost almost $4,000,000.

* * *

DEAN GORDON H. SCOTT of Wayne State University's College of Medicine was appointed in April as vice president for medical college development and Ernest D. Gardner, M.D., was named associate dean of the college of medicine.

Dr. Scott's new duties will consist of formalizing affiliation agreements with associated hospitals and coordinating plans for College of Medicine participation in the proposed Detroit Medical Center—a multi-million dollar redevelopment plan already approved by the federal government. He will retain the deanship but Dr. Gardner will assume many administrative duties.

Dr. Scott has been dean since 1950, while Dr. Gardner has been professor and chairman of the department of anatomy since 1950.



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Whiting Foundation Helps

The American Cancer Society conducted a closed conference of 50 American and foreign scientists to consider "The Possible Role of Immunology in Cancer." The conference held at Rye, New York, was financed in part by a gift made to the Society's Michigan division by the Whiting Foundation of Flint.

The proceedings will be made available later in a special edition of the *Cancer Research* journal.

Slides Available

The Michigan Cancer Registry has available for loan a group of study sets consisting of histologic slides, chiefly of various types of neoplasms. These sets are available without charge to all interested physicians in Michigan. A deposit is required and this will be refunded subject to possible deductions for loss or breakage. For further information please write to Director, Michigan Cancer Registry, 4811 John R Street, Detroit 1, Michigan.

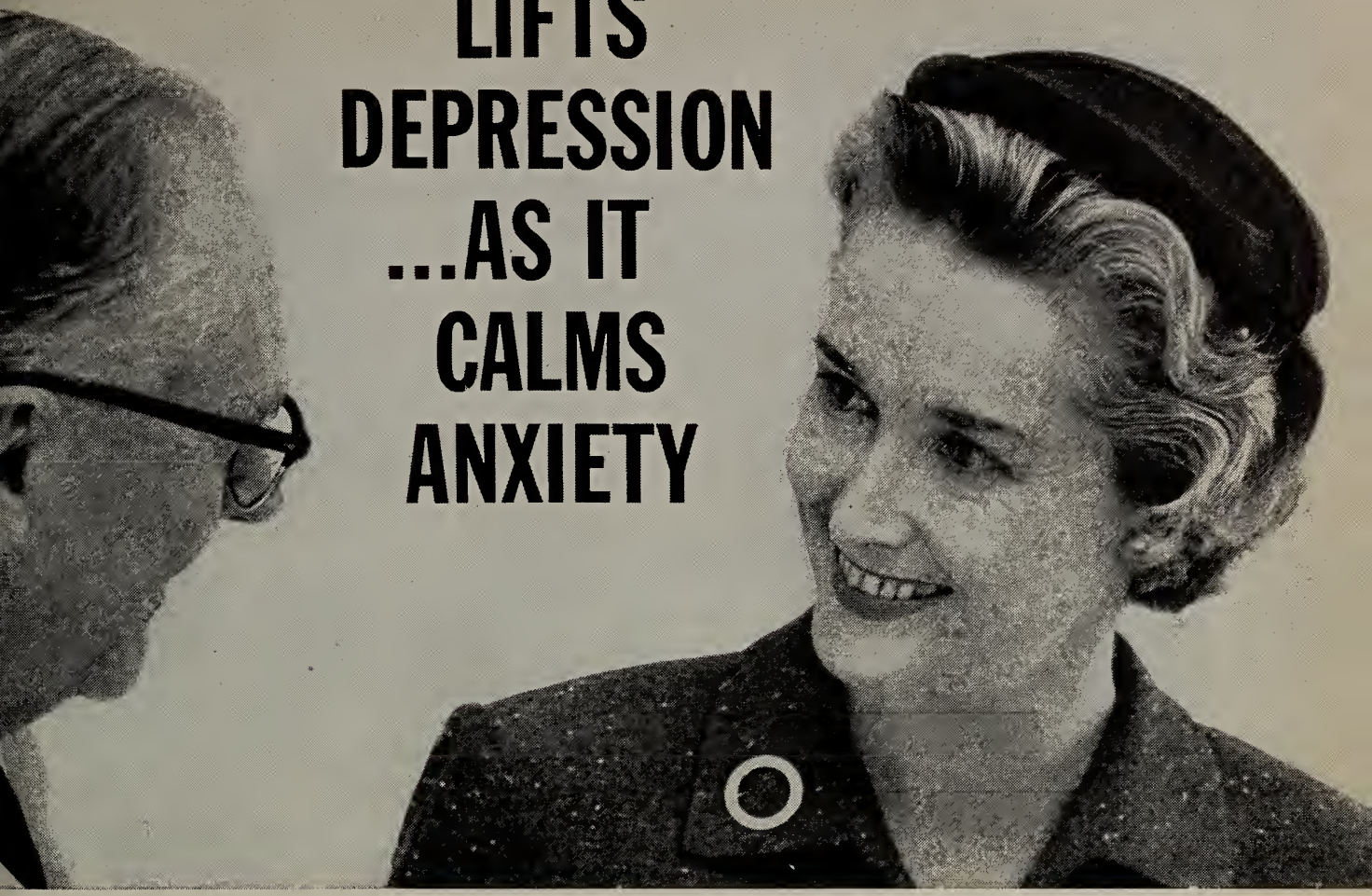


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Cancer Comment

Carcinoma of the Lung

Raymond J. Barrett, M.D.
Detroit, Michigan

Over the past half century, carcinoma of the lung has rapidly increased in incidence to the point where it is now most common cancer of the adult male patient. Being equally as lethal as carcinoma of the stomach, this almost explosive increase has led, on the one hand, to probably premature statements as to causation and, on the other hand, to an unnecessarily fatalistic attitude on the part of many who see the disease only occasionally.

Currently, it is the fashion to attribute a strong relationship to cigaret smoking, with the implication that cessation of smoking would be followed by a steadily decreasing incidence of the disease in the generations to follow. Many investigators, however, retain sincere doubts as to the cause and effect relationship between cigaret smoking and the development of lung cancer.

Studies in South Africa, New Zealand, and the United States on the difference in incidence of the disease between native-born and immigrant populations have been most stimulating in turning attention toward the role of air pollution and other environmental factors. Thus, native white South Africans, the heaviest smokers in the world, have a lung cancer rate less than half that of native-born inhabitants of Great Britain and Wales. Conversely, British immigrants to South Africa have a lung carcinoma rate half again as large as the native-born white South African, but less than that of those who remain in the British Isles. Similar findings have been reported from New Zealand, where it was also noted that the incidence of carcinoma increased with the age of the immigrant at the time of migration.

Traditionally, the incidence of the disease has been six to eight times as high in men as in women. When corrected for identical smoking habits, the ratio in the United States has ordinarily been halved. However, female immigrants to this country from Ireland, Italy, Norway, Sweden and Russia have a higher incidence of the disease than their male counterparts.

Once suspect and then apparently cleared, the internal combustion engine is again under scrutiny as the result of research on the problem of smog. Running at constant speed, the exhaust gases of a properly adjusted internal combustion engine are relatively low in content of carcinogenic and potentially carcinogenic agents. However, under acceleration and deceleration —conditions which obtain in city driving—the carcinogenic content increases.

Recent work would tend to indicate that we are possibly dealing with a virus as the primary etiologic agent and that a combination of factors previously discussed may predispose in the development of, or relative resistance to, the disease.

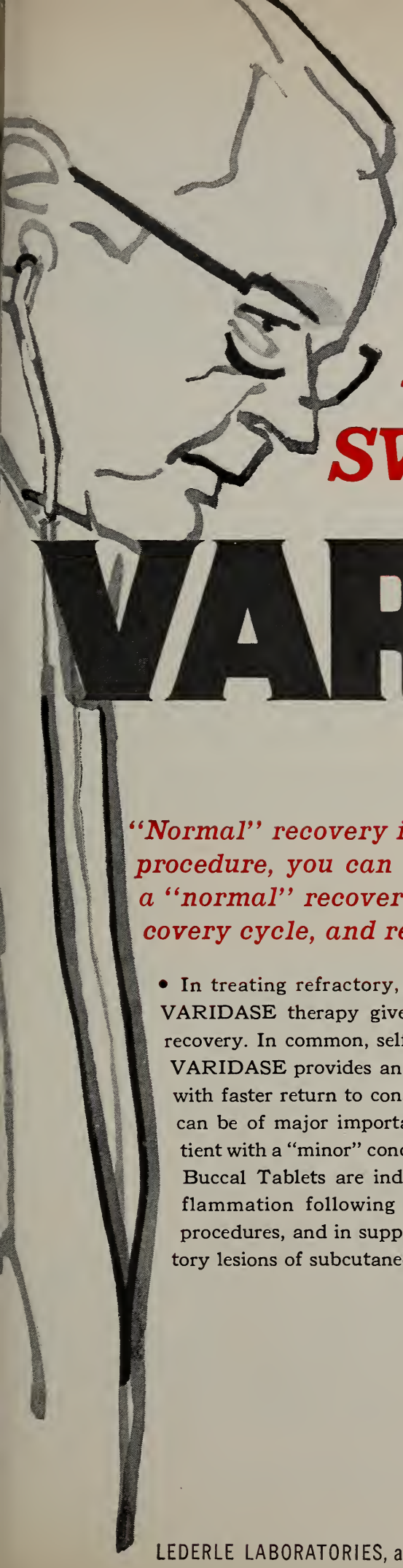
While research continues along the aforementioned lines, it seems reasonable to assume that we have at least a generation who are predisposed to develop the disease at an accelerating rate of rather alarming proportions. At a current annual fatality rate of approximately 38,000 from auto accidents and approximately 30,000 from carcinoma of the lung, the American man is already in more danger from the latter than the former.

Whatever the etiology, control of the disease *today* requires maximum effort toward early diagnosis and treatment. Detection of the asymptomatic patient who is harboring the disease, in the great majority of instances, will depend on a routine or mass survey film. In the latter, experience in major U. S. cities has shown an incidence of proven lung cancer varying from one in 8,000 to one in 14,000 of those surveyed. Higher yields would certainly be obtained if surveys were limited to men over age forty or forty-five. In such instances, one would be doing primarily a carcinoma survey, whereas most mass surveys encompass a wider group because of primary interest in the detection of tuberculosis. Despite the poor current yield, most studies have shown a higher respectability and survival rate in those picked up on surveys as compared to those whose diagnoses were made in the usual manner after the onset of symptoms.

Once the symptomatic patient has reached the doctor's hands, there is little excuse for failure to reach early diagnosis. Cough is the earliest and most constant symptom. A patient of the cancer age, sufficiently troubled by recent cough to consult a physi-

(Continued on Page 818)

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Carcinoma of the Lung

(Continued from Page 816)

cian, has received an inadequate consultation when the latter consists merely of application of the stethoscope and the dispensing of a favorite anti-tussive remedy. An x-ray examination is obviously indicated. Seldom will a patient, symptomatic from carcinoma of the lung, fail to reveal some abnormality in the chest roentgenogram. Finding of a roentgen abnormality in a symptomatic patient, in the age of high cancer incidence, demands immediate and continued investigation until the cause has been established. If a tenable diagnosis cannot be established by lesser diagnostic means, no hesitancy should be felt in proceeding to exploratory thoracotomy. Under such circumstances, the physician who elects to "follow" a nonresolving or progressive lesion takes an awesome responsibility upon his shoulders.

The sudden appearance of wheezing in a previously asymptomatic patient may not be accompanied by obvious x-ray changes. However, if one is aware that this symptom indicates some degree of airway obstruction, the logic of bronchoscopy is obvious.

That patient who is "fortunate enough" to have hemoptysis as an initial symptom has a much greater chance of a determined effort at early diagnosis, since bleeding is an ominous symptom to physician and layman alike. Even in the presence of a negative chest x-ray examination, this symptom demands bronchoscopy and, if this is negative, bronchograms. Cytologic examinations, when positive in the presence of a roentgenographically or bronchoscopically visualized lesion, are of great help—more often they will be negative and must not be allowed to lead one to a false sense of complacency.

Approximately one-third of patients with carcinoma of the lung, when referred to the thoracic surgeon, already exhibit signs of distant metastasis or local extension to the point where surgical intervention is obviously not feasible. The remaining two-thirds proceed to exploratory thoracotomy. Of these, about half the carcinomas will be found non-resectable, since complete removal of all visible or palpable tumor cannot be accomplished because of invasion of one or more of the numerous vital structures within the thorax. Therefore, in only half of the explored group (one-third of all cases) is it possible to perform a resection with hope of surgical cure. Although survival rates as high as 35 per cent have been reported, five-year survival in the vast majority of surgically resected carcinomas of the lung will not exceed 10 per cent.

Cure by irradiation therapy alone is extremely uncommon. On the other hand, in many cases it has a pronounced palliative effect in apparently restraining tumor growth for variable, and sometimes extensive periods. With few exceptions, therefore, I believe it should be used in all cases of non-resectable carcinoma. Applying the same reasoning, one might expect best results in attempting by irradiation, to eliminate microscopic mediastinal implants which were not visualized or palpated at the time of surgery. Since the latter condition could exist in any resection, one might recommend irradiation in all cases. On the latter point, there is considerable variation of opinion.

Chemotherapy of pulmonary tumors has been confined, in the main, to nitrogen mustard. Its most readily observable accomplishment seems to lie in the alleviation of the congestion attendant upon malignant invasion of the superior vena cava. On occasion, the subsidence of facial and upper extremity edema has been dramatic.

Carcinoma of the lung is a grave disease with ominous prognosis. Lest one become unduly pessimistic, it should be remembered that at present two-thirds of all cases are too far advanced for surgical removal when seen by the surgeon. If, by increased suspicion and more aggressive early diagnostic methods, this group could be halved, then automatically and using only currently available therapeutic methods, the number of five-year survivals could be doubled.

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Among the important changes for this *New (3rd) Edition* you'll find: New information on the low cholesterol diet for atherosclerotic disease—Revisions in the sections on vitamins and other food supplements—Inclusion of the new height-weight tables—The diets for children now accompany those for adults, for each condition.

By the COMMITTEE ON DIETETICS OF THE MAYO CLINIC. About 276 pages, 6"x9¼", wire binding. About $5.50.—*Just Ready! New (3rd) Edition*

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By ABRAHAM G. WHITE, M.D., F.A.C.P., Associate Visiting Physician and Chief of the Renal Disease Clinic, Queens Hospital Center, Jamaica, N.Y. 468 pages, 6½"x9¼", illus. $10.50. *New!*

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This volume gives you an immediately useful guide to diagnosis and therapy of thoracic disorders, both medical and surgical. Coverage embraces a host of management problems relating to diseases of the lungs, pleura, mediastinum and chest wall. The entire presentation emphasizes and integrates important cardiopulmonary relationships.

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Pathology Comment

These items are provided by the Michigan Pathological Society

Significance of Concentration of Serum Lipides

Lipemia Associated with Ketosis

Serum lipide levels are usually elevated in all conditions associated with ketosis. This lipemia results from the mobilization of fat from adipose tissue for direct utilization in the cell and for the conversion to ketone bodies in the liver. This is somewhat comparable to the lipemia seen after ingestion of fat. Lipemia is common in all types of uncontrolled diabetes, and in severe cases neutral fats are usually doubled, with cholesterol and phospholipides increased by 40 per cent. With successful management of the acidosis there occurs a rapid fall in the lipide levels due to restoration of normal carbohydrate metabolism.

Serum Lipides in the Nephrotic Syndrome

In the chronic stage of glomerulonephritis, in lipoid nephrosis, and in amyloid nephrosis the serum is lipemic. The rise is chiefly in the levels of cholesterol and neutral fats. The total lipide concentration is often 2000 mg. per cent or higher with total cholesterol levels of greater than 1000 mg. per cent. There are no symptoms directly ascribable to nephrotic lipemia and there is no ketosis. Liver function tests, with the exception of thymol turbidity, are usually normal.

Serum Lipides in Thyroid Disease

In hypothyroidism total cholesterol levels are usually elevated and conversely in hyperthyroidism serum cholesterol is low and rises to normal with treatment. In hypothyroidism the cholesterol level is only moderately raised and the neutral fats are not increased (as opposed to nephrotic lipemia). While the determination of cholesterol is of little diagnostic value in hyperthyroidism, it offers valuable corroborative evidence in hypothyroidism, especially when the BMR is doubtfully low.

Lipides in Liver Disease

In alcoholic fatty infiltration of the liver, serum lipides do not show any characteristic changes. There may be a slight fall in cholesterol esters, with the total cholesterol concentration unchanged. The changes in serum lipides that occur with obstructive jaundice, hepatitis, and cirrhosis are of great importance in diagnosis and prognosis.

Essential Hyperlipemia

The serum in this disease has a total lipide range from 1200 to 5000, phospholipides 450-1200, cholesterol 400-1200 mg. per cent. Triglycerides (neutral fat) make up the bulk of the serum lipides and fat embolism may occur. The pancreas is often involved and there is frequently glycosuria.

Xanthomatosis and Lipoidoses

Xanthomas may appear in numerous morphological variations and require laboratory information for their specific diagnosis, since the clinical features are too frequently non-specific. Xanthoma patients with *clear* serum have either normal or elevated values of their cholesterol, cholesterol esters and phospholipides, but no marked elevation in neutral fat. Xanthoma patients with *milky* serum have elevated neutral fat (600 mg. per cent or more) and may also show cholesterol and phospholipide elevations, but not in proportion to the increased neutral fat. Many patients show abnormalities in all lipide constituents. Therefore, it is important to obtain quantitative measurements on all lipide component fractions.

Serum Lipides and Atherosclerosis

Attempts have been made to link elevated serum cholesterol levels to the development of atherosclerosis. Recent ideas on the relationship of lipides to atherosclerosis are now centered around the neutral fat (triglyceride) fraction. Some investigators now share the opinion that this fraction is of greater importance than cholesterol in the development of atherosclerosis.[1]

AVERAGE NORMAL CONCENTRATIONS OF LIPIDE CONSTITUENTS

Constituent	*Range* (mg. %)
Total lipides	340-800
Neutral fat (triglycerides)	60-150
Total cholesterol	135-260
Free	40- 70
Esterified	95-200
Total phospholipide	156-390
Cholesterol/Phospholipide ratio	.8

Reference

1. Passananti, G. T., Guerrant, N. B. and Thompson, R. Q.: Effects of supplementary methionine and choline on tissue lipides and on the vascular structure of cholesterol-fed growing rats. J. Nutrition, 66:55-74, 1958.



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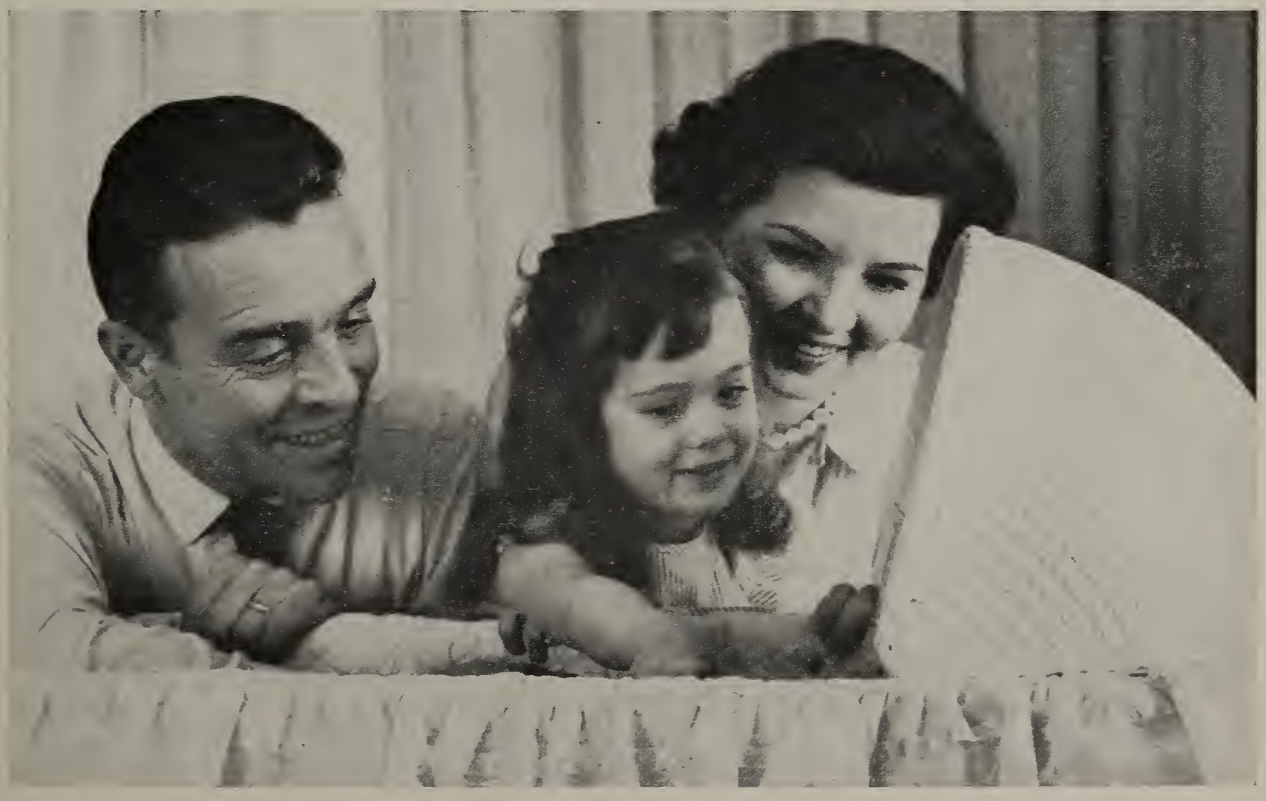
The new baby is beautiful, but his arrival raises some problems in family planning on which the mother will need help — *your* help. What you counsel or suggest to her may determine the family's happiness for many years to come. When she comes in to see you for her routine postnatal check-up, you have an ideal opportunity to counsel her and answer her questions. It's also an ideal time to recommend the use of Lanesta Gel.

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*Gamble, C.J.: Am. Pract. & Digest. Treat. *11*:852 (Oct.) 1960. See also Berberian, D.A., and Slighter, R.G.: J.A.M.A. *168*:2257 (Dec. 27) 1958; Kaufman, S.A.: Obst. and Gynec. *15*:401 (March) 1960; Warner, M.P.: J.Am.M. Women's A. *14*:412 (May) 1959.

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MICHIGAN DEPARTMENT OF HEALTH

ALBERT E. HEUSTIS M.D., State Health Commissioner

Limitations on Laboratory Examinations of Animal Heads for Rabies

Increased demands for examinations for rabies made to the Division of Laboratories of the Michigan Department of Health make it necessary to require much closer medical screening of specimens submitted. *Only specimens which meet the following criteria will be accepted for rabies examination:*

1. Human exposure as determined by a physician.
2. Animal exposure as determined by a physician or veterinarian, and then examination will be made only when necessary to establish a legal basis for destruction of the exposed animal.
3. Those specimens of special interest to the Department of Conservation.

Animal heads only will be accepted. Do not send or bring an entire carcass to the laboratory.

Pamphlet—Diagnosis of Phenylketonuria

A new pamphlet on the diagnosis of phenylketonuria has just been released. This is intended for use by professional personnel and not for general distribution to parents. Copies for physicians are available in limited number from the Division of Maternal and Child Health, Michigan Department of Health.

New Compliance Items for Nursing Homes and Homes for Aged

List No. 4 of the new compliance items for 1962 of the Rules and Regulations for Nursing Homes and Homes for the Aged has been released.

Clinic to Move

On May 1, 1961, the Detroit Social Hygiene Clinic will be moved from its present location at 660 Clinton Street, Detroit, to Building No. 7 at 8811 John C. Lodge Highway, adjacent to Herman Kiefer Hospital.

Rules and Minimum Standards for Hospitals

The revised edition of Rules and Minimum Standards for Hospitals has been published along with a revised legal definition of a hospital. A major change in the rules is that it is no longer necessary for a hospital to maintain a birth register. It is, however, still necessary to maintain a delivery room book; and infant records must include information sufficient to duplicate a birth certificate.

Laboratory Diagnostic Services for Virus Infections

The Michigan Department of Health will accept specimens from suspected cases of aseptic meningitis, polio-like infections and poliomyelitis beginning May 1, 1961. Specimens required for the laboratory diagnosis of these diseases will include feces, taken at the *acute* stage of illness, and acute and convalescent sera. These specimens will not be examined unless accompanied by a case history. Specimen kits for feces and blood specimens may be obtained from the Division of Laboratories, Michigan Department of Health, Lansing, Michigan. Directions for submission of specimens are provided with the kits.

The complete list of virus diseases for which laboratory diagnostic tests are available is as follows:

Virus Diseases	Specimens Required
Central Nervous System	
Poliomyelitis	Feces and paired sera, or paired sera only
Polio-like infections	Feces and paired sera
Aseptic meningitis	Feces and paired sera
Measles encephalitis	Paired sera
Mumps encephalitis	Paired sera
Herpes simplex encephalitis	Paired sera
Eastern equine encephalomyelitis	Paired sera
Western equine encephalomyelitis	Paired sera
St. Louis encephalitis	Paired sera
Lymphocytic choriomeningitis	Paired sera
Respiratory System	
Croup	Paired sera
Febrile catarrh	Paired sera
Non-bacterial pharyngitis	Paired sera
Influenza and influenza-like illness	Paired sera
Psittacosis	Paired sera
Rickettsial Infections	
Rocky Mountain spotted fever	Paired sera
Typhus	Paired sera
Rickettsial pox	Paired sera
Q fever	Paired sera
Other Virus Infections	
Epidemic keratoconjunctivitis	Paired sera
Rabies	Animal head or brain*

*Consult local health officer for information on method of submission of specimens.

Brief and to the Point

"CITIZEN OF THE YEAR"—W. H. Alexander, M.D., who went to the Upper Peninsula in 1925 on a two-year assignment but remained permanently to serve, is the 1961 "Citizen of the Year" in Iron Mountain. The award was made by the Lions Club.

Dr. Alexander, a native of Paterson, N. J., and a graduate of the University of Harvard school of medicine, was sent to the Upper Peninsula in 1925 by the Ford Motor Company to spend two years setting up Ford's medical program for the entire Upper Peninsula. When his work with Ford was completed, he stayed there to run up 36 years of continuous medical service to the community.

* * *

SURGEON CITED—An American Cancer Society Certificate of Merit recently was presented to Russell L. Mustard, M.D., Battle Creek, at a community program. The national recognition was for his work in the control of cancer.

* * *

HONORED AT CASSOPOLIS—D. H. Swengel, M.D., was honored recently at a Cassopolis open house celebration on his 80th birthday anniversary. A practicing physician for 53 years, Dr. Swengel has been at Cassopolis since 1940.

* * *

KAHN HONORED—Dr. Reuben L. Kahn(Sc.D.), Ann Arbor, has been elected an honorary life member of the Medical Society for the Study of Venereal Diseases in London.

* * *

RE-ELECTED HISTORIAN—Sidney Friedlaender, M.D., Detroit, was re-elected as historian of the American Academy of Allergy at its 17th annual meeting in Washington, D. C. Dr. Friedlaender has been a member of the executive committee of the Academy since 1959.

* * *

SPEAK IN NEBRASKA—Two Michigan doctors of medicine were guest lecturers at the 93rd annual session of the Nebraska State Medical Society in Omaha, May 1-4. Each man appeared twice. They were S. E. Gould, M.D., of Eloise, and John F. Holt, M.D., of Ann Arbor.

* * *

ANNOUNCEMENT—Applications for certification in the American Board of Obstetrics and Gynecology, new and reopened, Part I, and requests for re-examination in Part II are now being accepted. Deadline for receipt of applications is August 1.

Candidates are requested to write for a current bulletin so they may be well informed on the present requirements. Write to the American Board of Obstetrics and Gynecology, Office of the Secretary, Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio.

* * *

AWARDED GOLD-HEADED CANE—George Hoyt Whipple, M.D., 82-year-old New York pathologist who pioneered research in anemia, Whipple's disease, and metabolism, was named recipient of



the Gold-Headed Cane of the American Association of Pathologists and Bacteriologists at its annual meeting. Dr. Whipple is emeritus professor of pathology at the University of Rochester School of Medicine and Dentistry, Rochester, New York.

* * *

TALK IN GEORGIA—Ralph D. Rabinovitch, M.D., Northville, recently presented a paper before the Medical Association of Georgia, entitled, "Reading Retardation—a Psychiatric, Neurological and Educational Approach."

Jack Lapides, M.D., Ann Arbor, presented two papers at the same meeting about "Physiology of the Urinary Sphincter and Its Relationship to Operations for Stress Incontinence" and "Use of Renal Function Tests in Surgical Practice."

* * *

SEAT BELTS—The Chrysler Corporation announces that starting next fall all passenger cars built by the Corporation will contain built-in seat belt anchorages.

* * *

SPEAKS IN ENGLAND—Carl E. Badgley, M.D., Ann Arbor, addressed the British Orthopedic Association at Manchester, England, at its annual meeting.

* * *

EUROPE BOUND—Konstantin Scharenberg, M.D., Ann Arbor, will attend the Fourth Neouropathological Congress in Munich, Germany, and the Fourth International Neurological Congress in Rome, Italy, this autumn. He is to present papers at both meetings and also will visit research laboratories of neuropathology in these countries.

VISITING PROFESSOR—Russell N. DeJong, M.D., Ann Arbor, served as visiting professor of neurology at the University of California Medical School, San Francisco, in April.

* * *

SELECTIVE SERVICE ANNOUNCEMENT—Local Boards of the Selective Service System are requiring the classification of all physicians in internships which will terminate by June 30, 1961, who are now classified in Class II-A and who were born on or after January 1, 1934. This reclassification is made necessary by the failure of the military medical services to obtain from this year's interne group sufficient volunteers for commission and active duty beginning July 1961. The following categories are involved:

1. Physicians, non-fathers, under 26 years of age on July 1, 1961, now in Class I-A or Class I-A-O, with the oldest listed first;
2. Physicians, fathers, as above;
3. Physicians born in 1935 who will be 26 on July 1, 1961, classified as above, with the youngest listed first; and
4. Physicians born in 1934, classified as above, with the youngest listed first.

The hazard to the involved hospital in justifying "essentiality" has been noted before.

* * *

GIVES RUSSEL LECTURE—Jerome W. Conn, M.D., Ann Arbor, delivered the Henry Russel Lecture May 4 at the



University of Michigan. Selection of the Russel Lecturer each year by the U-M Research Club marks the highest honor The University of Michigan can give a senior faculty member. Dr. Conn is the author of more than 150 scientific publications and has won national and international recognition as a clinical investigator in the field of endocrinology and metabolism.

* * *

ADDRESSES ACHA—John M. Dorsey, M.D., Detroit, was the principal speaker at the annual banquet of the American College Health Association at Wayne State University, April 7. About 400 doctors, nurses, psychologists and public health and social workers attended.

* * *

TO INTERN IN STATE—Two-thirds of the June graduating class of The University of Michigan Medical School will take internship training at 23 Michigan hospitals. Of the 178 graduates, 117 have been selected by Michigan hospitals.

* * *

STUDIES IN RUSSIA—Fred M. Davenport, Ann Arbor, has been invited to be one of six American investigators who are to make a study of virological investigation in the Soviet Union under sponsorship of the U. S. Public Health Service and the U. S. Department of State.

* * *

ON "REHAB" COMMITTEE—Only Michigan appointee to the national "Ad Hoc Committee for Study of Rehabilitation Facilities" is Joseph N. Schaeffer, M.D., of Detroit. Dr. Schaeffer, chairman of the Wayne State University department of physical medicine and rehabilitation, is director of the Rehabilitation Institute of Detroit.

The Ad Hoc committee will meet periodically in Washington to evaluate progress made in the health field and to more clearly define anticipated expenditures and needs.

* * *

HONORED—Chrysler Corporation was awarded the 1961 Health Achievement in Industry award from the Industrial Medical Association. Marion Jocz, M.D., Chrysler medical director, was thus signally honored for his long-time and progressive medical and health policies in industry.

* * *

RESEARCH GRANTS—Nearly 300 agencies across the nation received grants totaling $592,485 from Smith Kline & French Foundation during 1960. The trustees' report reveals that since its beginning in 1952, the Foundation has given grants of $4,026,223 to charitable, educational and scientific organizations.

* * *

ANNOUNCE WAYNE COURSES—The Department of Psychiatry of Wayne State University College of Medicine will offer two Postgraduate Intensive Courses in Psychiatry this summer, each one combined with a seven-day recreation week for participating doctors and their families. The first course will be at Blaney Park Resort, Blaney Park, Michigan, July 9 through 16. The second

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course will be at Charlevoix Beach Resort Hotel, Charlevoix, August 6 through 13. Classes will consist of three seminars held daily for the doctors, and one daily seminar for the doctors' wives.

For information, write Dr. Henry Krystal, Director, Postgraduate Education, Department of Psychiatry, W.S.U. College of Medicine. Address: Department of Psychiatry, Detroit Receiving Hospital, Detroit 26, Michigan.

* * *

PLANS ADVANCED—More than 5,000 public health specialists are expected to attend the 89th annual meeting of the American Public Health Association in Detroit, November 13-17. About 60 related organizations will meet at the same time, all at Cobo Hall.

Joseph G. Molner, M.D., Detroit, is chairman of the local arrangements committee of which MSMS Executive Director Wm. J. Burns is a member.

The APHA has more than 13,000 members.

* * *

USPHS RESEARCH FELLOWSHIP—Edward C. Heath, Ph.D., assistant professor of bacteriology in The University of Michigan Medical School, has received a United States Public Health Service Senior Research Fellowship, effective about July 1.

The fellowship provides complete support for the faculty position plus an extra $7,500 for the individual's research program.

It lasts for a five-year period, and is awarded to scientists chosen from a field of applicants from all over the country. Each institution is permitted a limited number of applicants.

* * *

SOURCES OF FINANCIAL AID TO MEDICAL STUDENTS—Each year the Association of American Medical Colleges and its member schools receive a great many requests for information on financial aid available to medical students. As a part of the Association's intensive action-program dealing with the problem of medical student finances, a brochure entitled *Sources of Financial Aid to Medical Students* has been published. This brochure is designed to help medical students and prospective applicants to medical school get in touch with the individuals in each State in the U.S. who can provide concrete information and help on the problem of financing the cost of a medical education.

Every effort has been made to make the listing of sources of financial aid as current as available information permits. The Association would appreciate it if readers of the brochure would supply names and addresses of any agencies or organizations which should be added to the list.

Copies may be obtained by writing to Dr. Ward Darley, Executive Director, AAMC, 2530 Ridge Ave., Evanston, Illinois.

* * *

REPORTS PROGRESS—The Southeastern Michigan Division of the American Cancer Society reports that 5,000 Detroit-area women viewed the recent educational films in 10 Detroit theatres. The special film program for women also included the distribution of literature by volunteer workers.

(Continued on Page 828)

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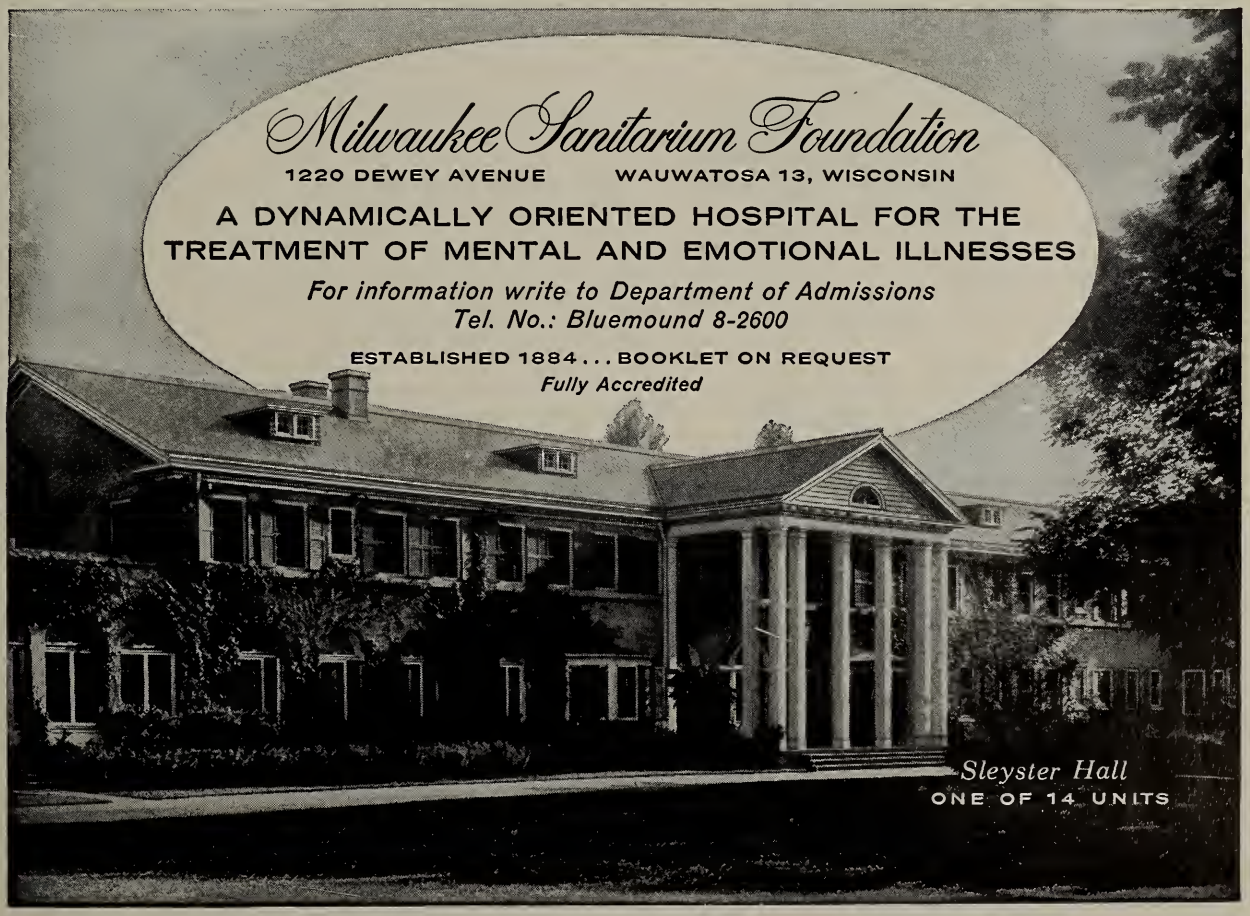
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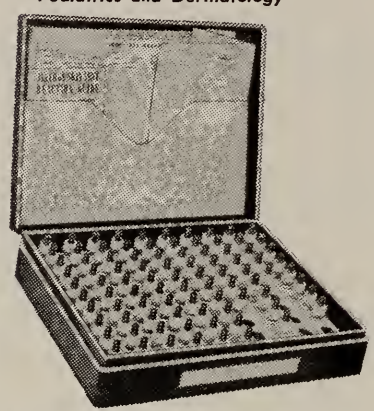


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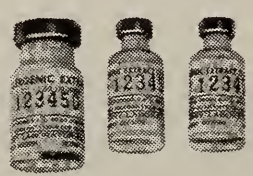
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(Continued from Page 826)

MEDICAL MEETINGS, U.S.A.

International College of Surgeons, New England Regional Meeting, July 1-4, 1961, Chatham Bars Inn, Chatham, Cape Cod, Mass.

American Physical Therapy Association, July 2-7, 1961, Palmer House, Chicago. Lucy Blair, 1790 Broadway, New York 19, Executive Director.

Association of Hospital and Institution Libraries, Division of the American Library Association, July 9-15, 1961, Cleveland Public Auditorium, Cleveland. For information, write American Library Association, 50 E. Huron St., Chicago 11.

National Medical Association, Aug. 7-10, 1961, Commodore Hotel, New York. John T. Givens, M.D., 1108 Church St., Norfolk, Va., Executive Secretary.

Rocky Mountain Radiological Society, Aug. 10-12, 1961, Denver Hilton Hotel, Denver. John H. Freed, M.D., 4300 E. 9th Ave., Denver 20, Secretary-Treasurer.

American Veterinary Medical Association, Aug. 20-24, 1961, Sheraton Cadillac Hotel, Detroit. H. E. Kingman, Jr., D.V.M., 600 S. Michigan, Chicago, Executive Secretary.

Biological Photographic Association, Aug. 21-24, 1961, Pick-Congress Hotel, Chicago. Mrs. Jane W. Crouch, Box 1668, Grand Central P.O., New York 17, Executive Secretary.

American College of Physical Medicine and Rehabilitation, Aug. 27-Sept. 1, Sheraton-Cleveland Hotel, Cleveland. Dorothea C. Augustin, 30 N. Michigan Ave., Chicago 2, Executive Secretary.

American Fracture Association, Sept. 17-21, 1961, Shoreham Hotel, Washington, D. C. H. W. Wellmerling, M.D., 610 Griesheim Bldg., Bloomington, Ill., Executive Secretary.

American Society of Plastic and Reconstructive Surgery, Sept. 24-29, 1961, Roosevelt Hotel, New Orleans. T. Ray Broadbent, M.D., 508 E. S. Temple, Salt Lake City, Secretary.

American Hospital Association, Sept. 25-28, 1961, Atlantic City. Mr. Maurice J. Norby, 840 N. Lake Shore Dr., Chicago 11, Secretary.

American Roentgen Ray Society, Sept. 26-29, 1961, Deauville Hotel, Miami Beach, Fla. C. Allen Good, M.D., Mayo Clinic, Rochester, Minn., Secretary.

American Association of Medical Clinics, Sept. 27-29, 1961, Barbizon Plaza Hotel, New York. Joseph B. Davis, M.D., Davis Clinic, 131 N. Washington St., Marion, Ind., Secretary-Treasurer.

American Association for the Surgery of Trauma, Sept. 28-30, 1961, Drake Hotel, Chicago. William T. Fitts, Jr., M.D., 3400 Spruce St., Philadelphia 4, Secretary.

College of American Pathologists, Sept. 30-Oct. 3, 1961, Seattle. For information write: A. H. Dearing, M.D., Prudential Plaza, Suite 2115, Chicago 1.

American Society of Clinical Pathologists, Sept. 30-Oct. 8, 1961, Olympic Hotel, Seattle. Miss Eleanor F. Larson, 445 N. Lake Shore Dr., Chicago, Manager.

Say you saw it in the Journal of the Michigan State Medical Society

IN MEMORIAM

CLIFFORD F. BRUNK, M.D., sixty-nine, of Old Mission, died April 15, 1961.

Until his retirement eight years ago, he had practiced medicine in Detroit for thirty-one years. He was an ear, nose and throat specialist and served on the staff of Jennings Hospital.

A graduate of Goshen College and Ohio State University, he was a member of the American College of Surgeons. He belonged to the University Club, Country Club of Detroit, Bayview Yacht Club, the Players and the American Legion.

SAMUEL W. DONALDSON, M.D., sixty-nine, American College of Radiology gold medal winner and head radiologist at Ann Arbor's St. Joseph Mercy Hospital, died April 6, 1961.



Doctor Donaldson had been with the hospital for thirty-one years and directed installation of all its x-ray equipment. He received the gold medal, the ACR's highest honor, in 1955 for research on the statistics of radiologic practice. He also was author of several books on his specialty, including one on radiological testimony in court.

He was born in Rockford, Tennessee, received a bachelor's degree from the University of Tennessee and in 1916 graduated from the University of Michigan medical school.

He was a fellow of the American College of Radiology. Memberships included American Roentgen Ray Society, Radiological Society of North America, Detroit X-Ray and Radium Society. Dr. Donaldson was a past president of Washtenaw County Medical Society, Detroit X-Ray and Radium Society and Michigan Association of Radiologists.

HOMER E. ISLEY, M.D., fifty, of Blissfield, died February 10, 1961.

Born in Wellsville, Michigan, Doctor Isley graduated from Blissfield High School, and from Michigan State University in 1933 with a degree in chemical engineering.

After a refresher course at Adrian College, he entered the Louisville, Ky., School of Medicine, from which he received his degree in 1942. He interned and served as resident physician at Lucas County Hospital, now Maumee Valley Hospital, from 1942 to 1944.

He served as a captain in the Army Air Corps during World War II. Following his discharge in 1946, he established his practice in Blissfield.

He was a past president of the Lenawee County Medical Association.

GEORGE A. KAMPERMAN, M.D., eighty, Detroit physician, died March 30, 1961.

Doctor Kamperman received his medical degree in 1907 from University of Michigan. Until 1912, he was assistant in obstetrics and gynecology at University Hospital.

He was chief of the Department of Obstetrics and Gynecology at Harper Hospital from 1921 to 1944, serving as chief of staff from 1933 to 1944.

Memberships included Detroit Academy of Medicine, American College of Surgeons, Detroit Athletic Club, American Gynecological Society and the American College of Obstetricians and Gynecologists.

A native of Zeeland, he had lived in Detroit since 1913.

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COMMUNICATIONS

K. H. Johnson, M.D.
President
Michigan State Medical Society
Lansing, Michigan

Dear Doctor Johnson:

I want to thank you most sincerely for your kind words about my recent television debates with Mr. Reuther. I am gratified that I was able to represent American medicine against a very skillful debater.

The reactions to my appearance deepened my conviction that everyone must join actively in the monumental effort to preserve the highest quality of medical care without government regulation. Every doctor, every community leader and industrial spokesman must not sit back and let others do the job. Every one of us has the obligation to fight for our principles.

Again, thank you for your message.

Sincerely,
EDWARD R. ANNIS, M.D.

Dear Dr. Haughey:

On page 364 of the JMSMS, March issue, you have made a few references to the Study of Hospital and Medical Economics. I should like to comment briefly on them.

There is no question but that hospital, medical and prepayment groups in Michigan have cooperated with the Study. They have not only given assent to have records examined, but beyond this have spent appreciable time answering questions, using staff to track down information and the like. Furthermore, the quality of the help has been excellent.

The report was not promised for May 1959. The Study did not get underway with intensity until the summer of 1958, some staff members were not recruited until the end of 1958 and by the spring of 1959 intensive field work had only begun. In 1959 it was stated that a few reports would be ready in the spring of 1960. These have been delayed for two reasons, i.e., the volume of work has been greater than anticipated and a policy decision was made, contrary to what was planned initially, to not release one report until all were finished. The close interrelationship of the projects became more obvious to the staff as the work progressed.

The data released to Senator McNamara were cleared as a matter of courtesy with the Commission and immediately made public. Copies of the testimony were included in board minutes of Blue Cross and Blue Shield. The data were essentially descriptive and contained no interpretations or recommendations.

At various junctures during the course of the Study representatives of MSMS, Michigan Hospital Association and other groups have been asked to come to Ann Arbor to observe the progress of the work. There has been no attempt to fashion a punitive tool, rather information regarding objectives, methods and even some preliminary findings has been shared in an effort to create interest in the problems under study and pave the way for whatever changes are indicated.

The Study will be discussed with the Governor's Commission on May 13, May 27 and June 3. On each day, material covered will be released immediately to the public. Previous to each meeting the material will be reviewed by the Policy Committee of the University. Three meetings of the Commission have been set because of the bulk of the manuscript.

The Study will be published for wide distribution by the American Hospital Association. A publication date has not been set but the editorial staff of the Association is at work now.

Sincerely yours,
W. J. MCNERNEY, *Director,*
Bureau of Hospital Administration
University of Michigan

Ann Arbor, Michigan
April 4, 1961

Journal Michigan State Medical Society
Lansing, Michigan

Dear Sir:

You invited comment on your May, 1961, issue recently sent to me. I have enjoyed every article to the fullest. I agree that compulsory retirement at a chronological age is a fallacy. I am hoping that this categorizing of the elderly will lessen in emphasis, and probably it will, if planning be done on a total community pattern. I, too, view with alarm the increasing tendency toward the welfare state, particularly on a chronological basis.

Need is need, regardless of age. I also view with greater concern the shifting of family responsibilities to social agencies and institutions. There is truth in those so-captioned "Socio-Economic Trends," but let's not lose sight of the spiritual and indestructable value that can preserve the togetherness of family units.

I didn't intend to proceed at such length, but I am votally interested. I have been in the field since 1952, and I should add that I am only a volunteer, past and present.

Sincerely yours,
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Michigan Authors

George Moriarity, M.D., Eiki Makino, M.D., and Raymond Husband, M.D., Detroit, "Gems and Stratagems 1961 Meeting, American College of Surgeons," *Harper Hospital Bulletin*, January-February, 1961.

Murray B. Levin, M.D., and Hermann Pinkus, M.D., Detroit, "Autosensitivity to Desoxyribonucleic Acid (DNA)," *The New England Journal of Medicine*, March 16, 1961.

F. Deborah Johnson, M.D., and Donald R. Korst, M.D., Ann Arbor, "Pancytopenia Associated with Sulfamethoxypyridazine Administration," *Journal, American Medical Association*, March 18, 1961.

Sidney Friedlaender, M.D., and Alex S. Friedlaender, M.D., Detroit, "Parenteral Steroids in the Management of Acute Allergic States," *American Practitioner and Digest of Treatment*, March, 1961.

Andrew F. Caughey, Jr., M.D., Detroit, "Electronic Detection of Fetal Life," *Obstetrics and Gynecology*, March, 1961.

P. U. Fechner, M.D., Ann Arbor and Eloise, "Influence of Corticotropin (ACTH) on Healing of Corneal Ulcers in Guinea Pigs," *Archives of Ophthalmology*, April, 1961.

H. Saul Sugar, M.D., Detroit, "Surgical Treatment of Tumors of the Orbit," *Eye, Ear, Nose and Throat Digest*, April, 1961.

R. W. Talley, M.D., V. K. Vaitkevicius, M.D., M. J. Brennan, M.D., and J. E. Kelly, M.D., Detroit, "Intra-arterial Chemotherapy of Malignant Diseases," *Henry Ford Hospital Medical Bulletin*, March, 1961.

Joseph P. Abraham, M.D., Shirley A. Johnson, Ph.D., Orhan N. Ulutin, M.D., and M. June Caldwell, B.A., Detroit, "Hemorrhagic Complications of Polycythemia Vera," *Henry Ford Hospital Medical Bulletin*, March, 1961.

Leonard E. Himler, M.D., Ann Arbor, "Emotional Problems in Industry: Recognition and Preventive Measures," *Industrial Medicine and Surgery*, April, 1961.

T. Manford McGee, M.D., Detroit, "Streptomycin Sulfate and Dihydrostreptomycin Toxicity," *Transactions, American Academy of Ophthalmology and Otolaryngology*, March-April, 1961.

Marvin W. Woodruff, M.D., Richard L. Malvin, Ph.D., and Ian M. Thompson, M.D., Ann Arbor, Michigan, "The Renal Transport of Nitrofurantoin," *Journal, American Medical Association*, April 1, 1961.

Thomas H. Rea, Jr., M.D., Ann Arbor, "The Cutaneous Lesions of Sarcoidosis," *The University of Michigan Medical Bulletin*, December, 1960.

John W. Sigler, M.D., Detroit, "Common Rheumatic Disorders," *American Practitioner and Digest of Treatment*, April, 1961.

G. Donald Albers, M.D., Grand Rapids, "Otometric Operations," *Archives of Otolaryngology*, April, 1961.

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Editorial Comment

White House Conference on Aging

(*Georgia Medical Journal*, March, 1961)

It is high time that physicians throughout our state realized that labor has pledged its vast resources to defeat the voluntary approach, that much is being done to undermine the physician image to achieve this end, and that already a ruthless campaign is in force to vilify and downgrade medicine. There is no doubt in our minds that the establishment of the financing of the health care under the current social security concepts will eventuate in government control of medicine, hospitals, dentistry, nursing services, and nursing homes, in fact, all of the health care fields.

Each physician must fight harder than he has before; he must fight at his local level as well as through his state and national organizations to combat this trend. Such a system represents more than "a foot in the door." It means the abolition of the private practice of medicine.—JOHN S. ATWATER, M.D., Atlanta.

Cautious Approach Needed

Battle Creek Enquirer-News, February 11, 1961

President Kennedy's health program for the aged—if it will work as he envisions it—sounds almost too good to be true. On the surface it seems to answer the need of the hour without a single objectionable feature. But, there are perils in it, nonetheless.

The program would be financed by only a fractional increase in social security taxes. As Mr. Kennedy sees it, the plan would be merely a prepaid insurance project and would create no additional burden on the federal treasury. An even more intriguing aspect is found in Mr. Kennedy's assurance that it is not a program of socialized medicine. The President contends that everyone would have absolute freedom of choice in selecting doctors and hospitals. And, he says there would be no supervision of control over the practice of medicine by any doctor or over the manner in which medical services are provided by any hospital.

This is unquestionably one of the most Utopian-appearing proposals ever submitted to Congress. But, will it work out in practice?

It must be assumed, of course, that actuarial experts have already figured out the financial aspects and that, as of now, the one-fourth of one per cent increase in social security taxes will cover the cost. In the case of workers earning at least $5,000 per year, this tax increase would eventually amount to $18.50 annually, for both employe and employer. This is only a small fraction of the yearly premium on most medical care insurance plans.

The dangers in Mr. Kennedy's proposal do not lie in the financial field. Instead, it is the matter of federal control over doctors and medical care with which concern must be expressed. Regardless of the President's protestation that the plan is not socialized medicine and that no federal supervision of doctors and hospitals would be imposed, the history of American bureaucracy contradicts him.

It has long been the rule in government that when federal funds are dispersed, certain criteria formulated in Washington always must be adhered to by those who receive the money. The current federal highway program is an outstanding example of federal dictation to the states that get road building funds. No matter what local highway requirements may actually be, the Bureau of Public Roads has the final say on how the roads may be constructed and marked.

There is no reason to optimistically presume that the medical care program would be immune to such federal control. The only way to insure against it would be in the wording of the law itself—a matter that Congress should consider carefully. The regimentation of doctors and hospitals cannot be condoned.

Therefore, the Kennedy proposal must be approached with considerable caution, lest it become a monster that could destroy the finest system of medical practice and care the world has ever known.

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The Doctor's Library

Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

FETAL PHYSIOLOGY AND DISTRESS. Edited by Thaddeus L. Montgomery, M.D. ENDOCRINOLOGY. Edited by Robert B. Greenblatt, M.D. Clinical Obstetrics and Gynecology, Volume 3, Number 4, December, 1960. New York: Paul B. Hoeber, Inc., Medical Division of Harper & Brothers. Series, $18.00 per year.

The section on Endocrinology presents many new as well as time-tested theories. The chapter on Hormones and Cancer disputes many fears on the use of hormones. The chapter on Thyroid Gland Preparations is very complete, especially in regard to its interplay with progesterone and aldosterone. This symposium is of interest to all who practice obstetrics and gynecology. It is not only an excellent review of the literature but gives the experience and theories of men who are renowned in their field, such as Greenblatt, Kistner and Zondek, to mention a few.

This volume is one of the most complete symposiums on fetal physiology and distress. The subjects include Causes and a Plan for Their Formation, Drugs and Anaethesia, Resucitation, Diagnosis and Treatment and the Mechanisms of Fetal Physiology. The chapters on Irradiation and the effect of Maternal Pre-diabetes are especially well written and give the newer concepts of two very important subjects. This symposium should be read by all who practice obstetrics because of its completeness and conciseness. Summaries, as well as references, are included at the end of each chapter.

J.R.P.

ATLAS OF OBSTETRIC TECHNIC. By J. Robert Willson, M.D., M.S. Professor of Obstetrics and Gynecology, Temple University School of Medicine, Philadelphia, Pa.; Head of the Department of Obstetrics and Gynecology, Temple University Hospital, Philadelphia, Pa. Illustrated by Daisy Stilwell. De Luxe Edition. St. Louis: The C. V. Mosby Company, 1961. Price, $14.50.

This Atlas serves the practitioner as an excellent reference to consult for operations for delivery. It is modeled after the atlases and texts devoted to descriptions of gynecological operative procedures. The book is primarily pictorial, with just enough reading matter to explain the pictures and diagrams. The material contains the normal as well as the abnormal, with emphasis on normal labor and delivery. The first two chapters also have an outline for the physical set-up of an obstetric department in a hospital, together with a section on Analgesia and Anaesthesia. This text should be on every hospital library shelf for reference by all persons doing obstetrics, as well as those doing surgery. It also would be most useful in the field of teaching.

J.R.P.

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LOSE WEIGHT AND LIVE. By Robert P. Goldman. Drawings by Roland Rodegast. Garden City, New York: Doubleday & Company, Inc., 1961. Price, $3.95.

Mr. Goldman shares with his readers a very sensible seven-point plan for losing weight without having to eliminate any special foods which are in the every-day pattern. It is a plan to change one's eating habits and does not involve following a special diet, or computing calories. Basically, he decreased the total amount of food consumed, ate smaller portions, eliminated one at a time certain high calorie foods, and very conscientiously became more active physically. All of these efforts together resulted in the proper weight loss which he has been able to maintain for several years. His wife contributes a chapter, giving hints as to how to encourage the weight-loser in his efforts.

W.H.

INSTRUCTIONAL COURSE LECTURES. The American Academy of Orthopaedic Surgeons. Volume XVII, 1960. Editor, Fred C. Reynolds, M.D., St. Louis, Missouri. Illustrated. St. Louis: The C. V. Mosby Company, 1960. Price, $18.50.

This volume, like its predecessors, is a selected compilation of certain of the instructional courses given at the preceding annual meeting of the American Academy of Orthopaedic Surgeons.

For the benefit of those not familiar with this procedure, these courses represent from one-hour to three-hour presentations on a given subject by the man, or men, considered best qualified throughout the country, or even from foreign lands. The discussion, therefore, tends to approximate the appreciation level of those familiar with the routine aspects of these problems and interested in a more penetrating grasp of the material.

Of the five parts in this volume, two are symposia. One involves athletic injuries and the other, bone graft surgery. The remaining three cover fractures, children's orthopedics, and a miscellaneous group.

As before, for those who practice more than occasional orthopedics, the series remains a must item.

R.H.A.

MANAGEMENT OF FRACTURES, DISLOCATIONS, AND SPRAINS. (Key and Conwell's). By H. Earle Conwell, M.D., F.A.C.S., Associate Professor of Orthopedic Surgery, University of Alabama School of Medicine, Birmingham, Alabama; Attending Orthopedic Surgeon, University Hospital, St. Vincent's Hospital, Children's Hospital, Baptist Hospitals, East End Hospital, and South Highlands Infirmary, Birmingham, Ala.; Consulting Orthopedic Surgeon, Veterans Hospitals, Tuscaloosa, Ala. and Montgomery, Ala.; Chief, Conwell Orthopedic Clinic, Birmingham, Ala.; and Fred C. Reynolds, M.D., Professor of Orthopedic Surgery, Washington University School of Medicine, St. Louis, Mo. Seventh Edition. 1,227 illustrations. St. Louis: The C. V. Mosby Company, 1961. Price, $27.00.

Quite a thorough revision has occurred since the previous edition, and all to the good.

This text has always been a standard reference work, although it admittedly does not cover every conceivable injury in encyclopedic fashion. One of its strong points is

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that the basic discussion of each entity reflects, obviously, the authors' beliefs, yet there is usually added a brief discussion of other authors' opinions, together with a good bibliography.

The illustrations are well done and plentiful. The volume deserves a place on the shelf of both amateur and expert.

R.H.A.

711 MEDICAL MAXIMS. Volume II. By William S. Reveno, M.D., Associate Professor of Clinical Medicine, Wayne State University College of Medicine; Physician, Harper Hospital and Detroit Receiving Hospital, Detroit, Michigan. Springfield, Illinois: Charles C Thomas, 1961. Price, $3.50.

Dr. Reveno's collection of maxims, which he has garnered over a number of years, were first published in book form ten years ago. He has contributed them to the *Detroit Medical News*, the *Journal of the Michigan State Medical Society*, and to other publications. These maxims are terse, short statements of medical observations, ideas for diagnosis, for treatment, et cetera. They are extremely well done, and one is tempted to keep on reading them. This volume is again divided into a number of sections with the maxims classified in the various sections. It is a wonderfully appealing list of observations which one can use many times in his day of work. A look into any section will usually give the answer to the question one had in mind.

We are very much pleased and very happy to have this second volume of Dr. Reveno's observations from a very extensive and almost unique facility for study.

BOOKS RECEIVED

THE CHANGING YEARS. The Menopause without Fear. By Madeline Gray. New revised edition. Dolphin Books. Garden City, New York: Doubleday & Company, Inc., 1961. Price, 95c.

PYELONEPHRITIS. By Fletcher H. Colby, M.D., Consultant, Massachusetts General Hospital, former Chief of the Urological Service and Associate Clinical Professor, Harvard Medical School. Baltimore: The Williams and Wilkins Company, 1959. Price, $7.50.

INSULIN TREATMENT IN PSYCHIATRY. Proceedings of the International Conference on the Insulin Treatment in Psychiatry held at the New York Academy of Medicine, October 24 to 25, 1958. Edited by Max Rinkel, M.D., Boston, Massachusetts, and Harold E. Himwich, M.D., Galesburg, Illinois. New York: Philosophical Library, 1961. Price, $5.00.

OBSERVATIONS ON DIRECT ANALYSIS. The Therapeutic Technique of Dr. John N. Rosen. By Morris W. Brody, M.D. Forewords by John N. Rosen, M.D. and O. Spurgeon English, M.D. New York-Washington-Hollywood: Vantage Press, 1961. Price, $2.95.

MEDIEVAL AND RENAISSANCE MEDICINE. By Benjamin Lee Gordon, M.D., F.I.C.S. New York: Philosophical Library, 1961. Price, $10.00.

CLINICAL DISORDERS OF HYDRATION AND ACID-BASE EQUILIBRIUM. Second Edition. By Louis G. Welt, M.D., Professor of Medicine, Department of Medicine, University of North Carolina. Boston and Toronto: Little, Brown & Company, 1961. Price, $7.00.



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Volume 60 Number 7

July, 1961

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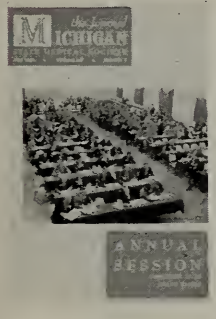
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THE COVER

MSMS House of Delegate members worked at conference tables, with notebooks for their reports, resolutions, notes, at the 1960 session held in Detroit. This year, the meeting swings back to Grand Rapids.

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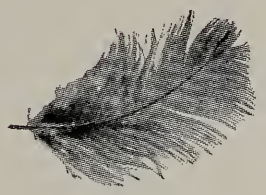
Delegates

	Term Expires
J. S. DeTar, M.D., Milan	1961
W. A. Hyland, M.D., Grand Rapids, *Chairman*	1961
O. J. Johnson, M.D., Bay City	1961
C. I. Owen, M.D., Detroit	1961
Wm. Bromme, M.D., Detroit	1962
R. L. Novy, M.D., Detroit	1962
G. W. Slagle, M.D., Battle Creek	1962

Alternates

	Expires
W. W. Babcock, M.D., Detroit	1961
G. B. Saltonstall, M.D., Charlevoix	1961
J. M. Wellman, M.D., Lansing	1961
B. M. Harris, M.D., Ypsilanti	1961
L. R. Leader, M.D., Detroit	1962
J. R. Heidenreich, M.D., Daggett	1962
D. N. Sweeny, Jr., M.D., Detroit	1962

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President's Page

WHICH CHOICE WILL YOU MAKE?



Kenneth N. Kuson

President
Michigan State Medical Society

Vacation time should be a good chance for each of you to rest and renew your energies for the long pull before us. It is gratifying to know that your friends and patients will also benefit if you are able to refresh yourself in these summer days.

The MSMS Council, at its recent mid-summer session, studied many problems. Even though a chance for a renewed spirit goes along with the summer days, the work must still go on. There is no opportunity for total relaxation.

Three-fourths of my term of office is over, and the days ahead will be a wind-up of the year. It seems quite apparent to me that very shortly we shall need to decide whether the Michigan State Medical Society may wish to coast along and hope for the best of the future—or whether it wishes to go all out in the way of time, energy, and money in playing an important part in plans for the future.

If the idea of coasting is the one we choose to follow, then we do not need to worry about anything, because it will be decided for us by those most eager to do so.

If, however, we choose to have a voice in what may happen next, we shall need to pull up our pants, take an extra hitch in our belts, and go to work as never before. I believe there are only these two choices.

Annual Session Offers Medical Authorities



Many of the outstanding authorities in medicine have been obtained as speakers for the 1961 Michigan State Medical Society Annual Session.

These medical teachers will come to Grand Rapids to present information of practical value to help the doctor in his daily practice. All presentations will stress diagnosis and treatment, applicable to clinical medicine.

The Annual Session is held in Grand Rapids every odd year, and the 1961 event will be held Wednesday, Thursday, Friday, September 27-28-29. The educational meeting once again follows the annual House of Delegates meeting Sunday, Monday, Tuesday, September 24-25-26. Once again, the events will take place at the Pantlind Hotel—Civic Auditorium.

Many other highlights are on the timetable along with the MSMS business sessions at the House of Delegates and the medical lectures and exhibits at the Annual Session. The inauguration of Otto K. Engelke, M.D., of Ann Arbor, as the new president will take place Tuesday night, when he succeeds Kenneth H. Johnson, M.D., Lansing. A social evening Thursday will be another added feature.

Speaking at the 1961 Annual Session will be the following:

Wednesday, September 27—Richard J. Bing, M.D., Detroit; Marcus R. Caro, M.D., Chicago; Lester P. Dodd, LL.B., Detroit; Richard Gorlin, M.D., Boston; Robert B. Greenblatt, M.D., Augusta; Saul B. Gusberg, M.D., New York City; Alexander B. Gutman, M.D., New York City; E. Richard Harrell, M.D., Ann Arbor; John R. Haserick, M.D., Cleveland; Clarence V. Hodges, M.D., Portland; Norman F. Miller, M.D., Ann Arbor; John H. Moyer, M.D., Philadelphia; and Mitchell J. Nechtow, M.D., Chicago.

Thursday, September 28—Wm. Altemeier, M.D., Cincinnati; Wm. S. Derrick, M.D., Houston; Cushman D. Haagensen, M.D., New York City; Lawrence C. Hampson, M.D., Quebec; Frank D. Lathrop, M.D., Boston; Gwilym S. Lodwick, M.D., Columbus; Lemuel C. McGee, M.D., Wilmington; Angus D. McLachlin, M.D., London; Hyrum R. Reichman, M.D., Salt Lake City; Bradley R. Straatsma, M.D., Los Angeles; and Homer H. Stryker, M.D., Kalamazoo.

Friday, September 29—Ernest E. Aegerter, M.D., Philadelphia; Ivan C. Berlien, M.D., Miami; J. Roswell Gallagher, M.D., Boston; Carl P. Huber, M.D., Indianapolis; Theodore A. Watters, M.D., New Orleans; and James L. Wilson, M.D., Ann Arbor.

MSMS Dedication Colorful Event



At right—As part of the deidcation program, Speaker of the House of Delegates J. J. Lightbody, M.D., Detroit, officially accepted the building from the architect.



Above—The flag-raising ceremony was impressive at the front of the building. The flag, given by Congressman Chamberlain, was raised by a National Guard unit.



At right—MSMS President Kenneth H. Johnson, during his address, announced AMEF checks to the two Michigan medical school deans, at right, Dean Gordon H. Scott of Wayne and Dean W. H. Hubbard of U-M.



At left—Relaxing after the dedication are William Jones, M.D., Menominee, chairman of the Big Look building committee, and Mrs. L. Fernald Foster, Detroit. Each contributed substantially to the furnishing of the building.



Major speaker at the dedication was E. Vincent Askey, M.D., California, president of the American Medical Association.



Mrs. Paul Ivkovich (*left*) of Reed City, president of the Woman's Auxiliary to MSMS, pins a dedication rose on visitors at the dedication-open house.



At left—Several past presidents of MSMS, chairmen of MSMS Council committees, and House of Delegates officials watched as the American flag was raised to begin the June 4 program. More than 1,000 viewed the dedication program.

HIGHLIGHTS of The Council

Meeting of April 19, 1961

Seventy-three items were presented to The Council at its April meeting. Chief in importance were:

- Special meeting of House of Delegates held in Lansing, April 16: review was presented by J. J. Lightbody, M.D., of Detroit. The Council authorized the implementation of the House of Delegates' recommendations concerned with adequate and proper medical care of the aged; each Councilor was made responsible for implementation of the plan in his Councilor District to maintain a sustained program. The Council voted commendation to Speaker Lightbody and Vice Speaker H. F. Falls, M.D., of Ann Arbor for preparing and executing an excellent meeting.
- Progress report on new MSMS headquarters was presented by K. H. Johnson, M.D., of Lansing. (a) Occupancy of the new headquarters had been made by MSMS with final inspection by the Big Look Committee to be made before final acceptance from the contractor and architect. (b) Landscaping is going ahead, all plants have been installed and grading will soon be completed so that the underground watering system can be piped. (c) The MSMS property at 606 Townsend in Lansing has been sold, with the transfer of property scheduled for May 11. (d) Plans for the June 4 dedication were outlined in detail by President Johnson and approved. (e) The lobby furnishings were dedicated to Doctor W. S. Jones (Chairman of the Big Look Committee) and Mrs. Jones of Menominee, with thanks to them for their generous contribution of time, thought, and financial help towards the erection of the new building.
- Secretary D. Bruce Wiley, M.D., presented report of AMA on articles unfavorable to Medicine appearing in national magazines. AMA Executive Vice President F. J. L. Blasingame, M.D., advised that there had been in operation at AMA headquarters considerable staff activity on this problem. "When unfavorable articles appear, protests generally are made face to face with the editors involved and also through letters signed by AMA officials." He felt that an increase in the number of articles involving Medicine can be expected because of the present spotlight re financing health care of the aged.
- Report on successful 1961 Michigan Clinical Institute: registration totaled 2,626 including 1,450 M.D.'s (190 more M.D.'s than at 1960 MCI). Attendance at the eight Discussion Groups averaged 36 per, higher than originally planned.
 G. B. Saltonstall, M.D., of Charlevoix was named General Chairman of the 1962 Michigan Clinical Institute's Committee on Arrangements.
- American Medical Education Foundation checks to 85 medical schools will not be sent direct this year but through state medical societies. The Council instructed that the checks to the U-M Medical School and to Wayne State University College of Medicine be presented as part of the June 4 new building dedication ceremony.
- Plans for 1961 Annual Session of House of Delegates, to be held September 24-25-26 at the Pantlind Hotel, Grand Rapids, were presented by Speaker Lightbody. A reception for Delegates and Alternate Delegates in the new MSMS headquarters building in East Lansing, immediately prior to the opening session of the House of Delegates, was authorized.
- Constitutional Convention. The Council urged each Councilor to be a committee of one within each Councilor District to contact reputable citizens who might be willing to run for the office of delegate to Michigan's Constitutional Convention, and requested that component societies support such worthy candidates.
- U-M Study of hospital and medical economics in Michigan. The Council requested Professor W. J. McNerney, Director of the Study, to furnish MSMS with a copy of the report simultaneous with its release to the Governor's Commission May 14. Chairman Meier reported that Professor McNerney is scheduling three separate meetings with the Governor's Commission after which the information will be made available to the public. The Educational Liaison Committee was requested to implement the recommendations of the Report by releasing the salient points of the McNerny Report to MSMS.
- Medical Student's Conference. Wm. Bromme, M.D., was authorized to prepare an agenda and recommendations for appointments to the committee to organize the 1962 Conference.
- Proposals to expedite meetings of The Council (which have been running eight to ten hours each),

were authorized to be drawn up by a Committee composed of The Council Chairman, President, President Elect, Secretary and Speaker.

- Public Relations report included up-to-date information on (a) national and state legislation; (b) a Careers Conference at Alma College, July 7-8 (which the members of the MSMS Committee on Recruitment of Superior Medical Students were authorized to attend); (c) a conference on preparing Michigan's Constitutional Convention; (d) report on County-State Society Nights.
- Matters of mutual interest were discussed with Michigan Health Commissioner A. E. Huestis, M.D. The Council voted to support the Michigan Department of Health in gaining funds for care of tubercular patients on an out-patient basis at Howell (about $35,000 in order to save nearly $1,000,000).
- The report of the Finance Committee of The Council, meeting of April 19 was presented. This included: allocation of $200 as in the past, to each SAMA unit to assist delegates attending the national SAMA convention in Chicago; (b) the allocation of a $200 budget requested by Historian W. J. Stapleton, Jr., M.D., of Detroit; (c) review and approval of 1960 financial picture of State Medical Journal Advertising Bureau.
- Appointments: (a) The Council authorized participation in a School Health Workshop to be held at Eastern Michigan University, June 26 through July 8, sponsored by the Michigan Tuberculosis Association; this Workshop offered an opportunity for MSMS to sponsor an exhibit, and to send a resource person to explain the objectives and purposes of MSMS; (b) Regional Workshop on Home Care Programs, Chicago, May 24-26, sponsored by the A.M.A., American Hospital Association, Blue Cross Association, Association of Blue Shield Plans, and Public Health Service, to provide information at the regional level on home care programs and to explore ways and means at the state level of assisting in the development of home care plans. The Council authorized President Elect Otto K. Engelke, M.D. of Ann Arbor and Oscar D. Stryker, M.D., of Mt. Clemens to be official MSMS representatives; (c) Ontario Medical Association annual meeting, Toronto, May 10. Secretary D. Bruce Wiley, M.D., was authorized to attend this meeting.

In 1935, three out of every 1,000 Americans were ulcer victims. In 1960, 14 out of every 1,000 or 3 million Americans were victims, a 400 per cent increase. In that year, the ulcer had cost the U. S. 12 million workdays, 500 million dollars, and 10,000 deaths.

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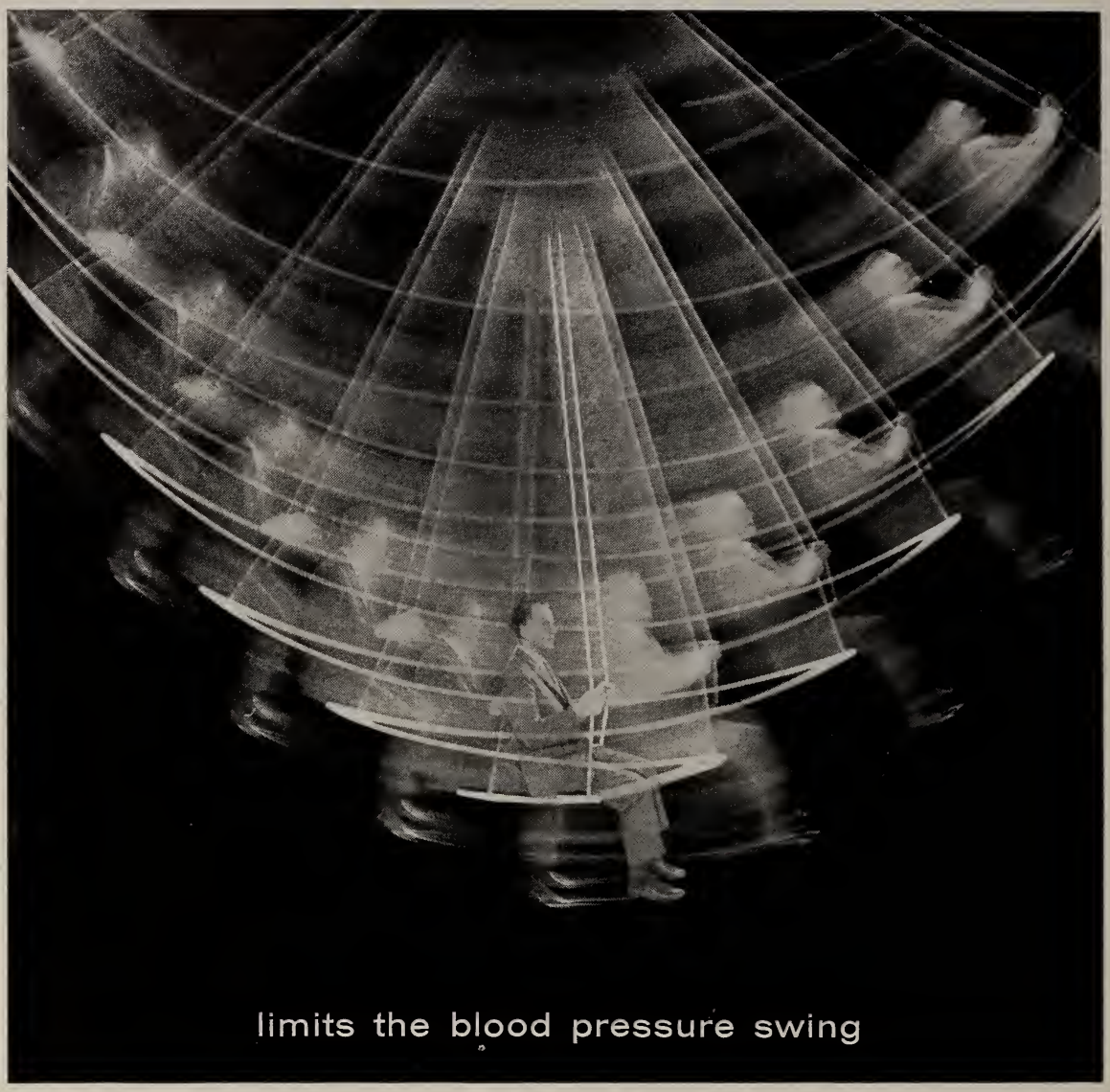
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MICHIGAN MEDICAL MEETINGS AND CLINIC DAYS

Sept. 24-25-26	MSMS House of Delegates	Pantlind Hotel, Grand Rapids
Sept. 27-28	Michigan State Medical Assistants Society	Occidental Hotel, Muskegon
Sept. 27-28	Woman's Auxiliary to MSMS	Pantlind Hotel, Grand Rapids
Sept. 27-28-29	MSMS Annual Scientific Session	Pantlind Hotel and Civic Center Grand Rapids

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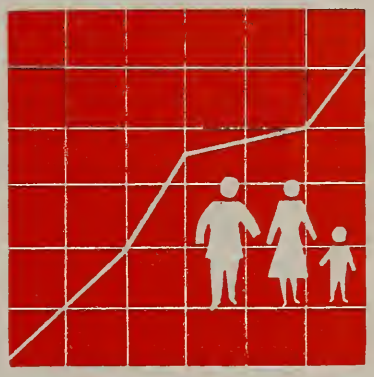
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Spokesmen Give Views At Blue Shield Meeting



More than 300 midwest doctors of medicine and Blue Shield staff members met in Detroit recently to exchange information and ideas on ways to make prepayment work more effectively. The meeting was the Midwest Conference of Blue Shield Plans, May 27-28 at the Statler-Hilton.

This conference covered Wisconsin, Michigan, Illinois, Indiana and Ohio officially. There were many other delegates from New York, Pennsylvania, New Jersey, Massachusetts, Montana and Iowa.

Donald M. Sweeny, M.D., Detroit, MMS board member and secretary of the Wayne County Medical Society, presided at the opening session. G. Thomas McKean, M.D., president, Michigan Medical Service, outlined the basis of the conference.

Madison Brown, M.D., Chicago, associate director of American Hospital Association, discussed the hospitals' positions, program and problems in providing health care to the public. Jerome Pollack, Detroit, program consultant for UAW-CIO and MMS board member, gave a talk on the socio-economic problems of medical care. Dan Reed, Lansing, legislative counsel of Michigan Farm Bureau, expressed many of the problems and wishes of the self employed from the standpoint of the Farm Bureau. Robert Ross, Detroit, manager of employee programs department, industrial relations staff, Ford Motor Company, stressed their willingness to work with all these groups in order to maintain the good health of employees.

Nearly 400 attended the evening dinner where James B. Blodgett, M.D., Birmingham, MMS board member, introduced Edward Annis, M.D., of Miami, the speaker, who is a Michigan boy from Detroit, a graduate of the University of Detroit, and a member of their debating team which won collegiate honors. His primary theme was "medicine has a service to sell." This service is continuously getting better, more extensive and more expensive. This will continue primarily because this service requires many assistants, employment of other people and pay for that employment. The doctor's services also require increasingly complicated facilities which cost a great deal of time, effort and money to build. "This is modern medicine, getting better every day," he stressed.

On Sunday, May 28, Harold G. Pearce, Detroit, director of MMS enrollment, led off and discussed the enrollment problems, programs and plans. Sidney Adler, M.D., Detroit, chairman of the Wayne County Review and Arbitration Committee and MMS board member, reported many of the studies and findings of his committee.

Professor Walter J. McNerney, director, Program in Hospital Administration U of M and study director, Governor's Study Commission on the Cost of Health Care in Michigan, gave a detailed discussion of many of the findings of the study.

Honorable Frank Blackford, Michigan Commissioner of Insurance, spoke about the place Blue Cross-Blue Shield has in furnishing health service to almost half the population of Michigan, their limitation to community rating and their necessity to be solvent. He said he could not find very much to criticize in the administration and functioning. Primarily he thinks costs are going too high and the public is going to demand another method of securing health care unless these criticisms change.

Bradley M. Harris, M.D., Ypsilanti, chairman, professional relations committee, MMS director, described the efforts and procedures of his committee in carrying through professional and public relations throughout the state, establishing various study and review committees to help with administering our Blue Shield program. Ernest Griffin, M.D., Flint, MMS board member, Sunday chairman, gave a short outline after conducting a quiz program allowing any one to ask questions of the panel members.

Medical Profession Given Challenge

New challenges to the medical profession are contained in the interim report of the Blue Shield Study Commission made at the recent Annual Conference of Blue Shield Plans. The Commission includes both representatives of AMA and the Blue Shield Plans.

The Study Commission made these statements:

"Blue Shield is the best and perhaps the only mechanism by which the medical profession, acting jointly with other community agencies, can provide the American people with a permanently acceptable system of prepayment for physician's services.

"But Blue Shield—in this year, 1961—is the great unfinished business of American Medicine.

"—If Blue Shield is to fulfill its mission—

"—If it is to obviate—once and for all—the need for the public to turn to other mechanisms which promise to solve quantitative problems at the expense of qualitative performance—

"—If it is to preserve the scientific integrity of medical judgment and freedom of choice for both patient and physician—

"Then Blue Shield must be strengthened—and the medical profession must assume its indispensable role of leadership in this task."

Blue Shield Grows

Enrollment in the nationwide Blue Shield Plans surpassed the 47,000,000-member mark at the end of 1960. Membership in the 74 medical-surgical Plans reached 47,084,988 on December 31, 1960, representing an enrollment of one out of every four Americans and nearly 15 per cent of the total Canadian population. The net gain in membership for 1960 amounted to 2,292,065.

Joins Blue Shield Family

North Idaho District Medical Service Bureau has been accepted as an active member of the National Association of Blue Shield Plans. The Lewiston-based Plan, established in 1946, has approximately 30,000 members enrolled.

Blue Shield To Offer New Uniform Program

Blue Shield Plans will soon offer an entirely new uniform program on a nationwide basis when a proposal adopted recently at the annual national meeting of the Blue Shield Association in Chicago is implemented.

This new Blue Shield program, one of the most significant achievements in the history of Blue Shield, will equip the organization to compete with full effectiveness for the first time in the enrollment of companies whose operations and employees are located across the nation.

Midwest Area Tops Nation In Health Insurance Benefits

The Health Insurance Institute reports that the Midwest was first in gain in actual dollar benefits in 1960.

The Midwest climbed from nearly $962 million to $1,034 million in benefits to show an increase of 7.5 per cent for its 12 states of Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota and Wisconsin.

The total amount of health benefits paid by insurance companies in 1960 was more than $3.1 billion, a boost of 8 per cent over the $2.9 billion distributed the year before.

Begin Indiana Building

The Indiana State Medical Association broke ground recently at Indianapolis for a new headquarters building. The cornerstone event will be October 24-26, with completion slated for March, 1962. The building will be white marble exterior, completely air conditioned, with office space and conference facilities.

* * *

U. S. Census Bureau reports size of average American family increased between 1950 and 1959 from 3.54 persons to 3.66. Southern families, with 3.81 persons, were larger than those in any other region.

* * *

Health gets about 14 per cent of the charity dollar, a late survey shows. Religion gets 50 per cent, welfare 16 per cent, education 15 per cent and other causes about 5 per cent.

Multiple Primary Lesions in the Head and Neck Areas

Their Therapeutic Approach with Supervoltage Irradiation

Ruth Guttmann, M. D.
New York, New York



THE OCCURRENCE of multiple primary malignant tumors in one individual has always been of great interest to me, and when I found a considerable number of patients who presented themselves with more than one malignant lesion in the head and neck area, I thought it might be worthwhile to study these patients especially carefully. This study has been interesting from many points of view, and has brought out some of the special problems connected with the occurrence of multiple primary lesions, among others the problem of their etiology, their early diagnosis and their treatment.

Etiology

In reviewing the charts of twenty patients who suffered from multiple primary carcinomas in the head and neck area, I found that all of them could be subdivided into three groups.

The first group refers to patients with precancerous lesions resulting in the development of malignant tumors of the mouth. These patients had leukoplakic changes in the oral cavity and developed separate lesions which arose from these leukoplakic changes, either simultaneously or with intervals ranging from months to years.

The second group deals with patients with various squamous cell carcinomas in non-adjacent parts of the oral cavity, for instance, in the right sublingual area and in the left anterior pillar of the fauces. This second patient group had lesions which were confined to the oral cavity, but which had started without visual evidence of precancerous conditions.

The third group consists of patients with various squamous cell carcinomas in widely separated areas; for instance, in the tonsillar fossa and in the esophagus.

While the patients with leukoplakic changes did not give any pertinent history as to the origin of the leukoplakia, we found excessive use of tobacco or chronic alcoholism in the history of a majority of the other patients.

I shall now discuss these three patient groups in some detail, with special reference to the diagnostic and therapeutic problems which were involved:

Presented at the Annual Session of the Michigan State Medical Society, Detroit, September 28, 1960.

From the Francis Delafield Hospital, Columbia University College of Physicians and Surgeons, New York, New York. This work was supported in part by a grant from the National Cancer Institute of the National Institutes of Health, Public Health Service.

Group I. Precancerous Lesions

There were five patients having precancerous lesions with rather similar histories. I shall therefore describe the course and management of only one.



Fig. 1

The patient, a woman, aged sixty-nine, had undergone surgery for a squamous cell carcinoma of the left muco-buccal fold in 1950, four years prior to admission to our hospital. She remained well until 1953, when she had an extensive local recurrence in this area, which again was treated surgically, though conservatively, because of the presence of leukoplakia in surrounding areas. She remained well until the beginning of 1954, when an extensive recurrence occurred and a second tumor was found in the palate together with widespread leukoplakia. She then was started on a course of radiotherapy with a 250 kv. unit. This treatment, however, was interrupted, as it was decided to send the patient to our hospital for further evaluation and treatment.



Fig. 2. 2000 kv., one port 8x10 cm.

At the time of the first examination at the Francis Delafield Hospital, it became evident that the patient suffered from one recurrent and one new lesion of the oral cavity (Fig. 1).

There was an area of leukoplakia on the left gum and an ulcer in the center of this area, which had been treated surgically before. In the muco-buccal area and in the palate, the mucosa was thick, red, elevated and showed whitish areas throughout. On the margin of the palate, there was an irregular ulceration, from which a biopsy had been taken recently and which showed squamous cell carcinoma. In the opinion of our pathologists, we dealt in this case as well as in the others of this group with two primary lesions, which is not a surprising diagnosis as leukoplakic changes are known to degenerate into malignant lesions in more than one place. This patient was in a bad situation. She suffered from widespread precancerous lesions some of which had changed to squamous cell carcinoma recently, others as long as four years previously, and for these the patient had been treated unsuccessfully by surgery. No lymph-node metastases had developed as yet.

The question of further therapy arose. The only thing surgery had to offer was a most radical procedure with an uncertain prognosis.

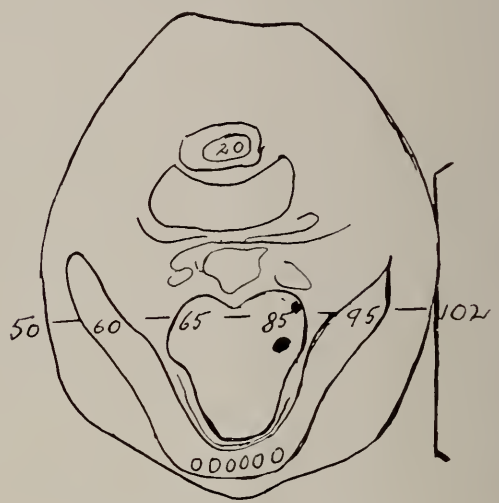


Fig. 3. 2000 kv., one port.

The radiotherapist was not in a much more enviable position. We had to take into consideration the previous, though small amount of irradiation which might allow us not to give a sufficient tumor dose and, most of all, the two surgical interventions which had changed the blood supply, thus making further therapy more difficult. Also we had to consider the necessity of treating not only the large areas of visible disease but also the areas of possible extension. Considering these various factors which had impaired the tolerance of normal tissues to further irradiation, namely previous surgery, and the small amount of previous irradiation, and also considering the fact that with a last all-out attempt large dosages had to be delivered through large fields, we decided to treat the patient with supervoltage therapy.

First, a few words as to why we have chosen this mode of treatment for these patients and what supervoltage irradiation (any type of therapy with voltages



Fig. 4



Fig. 5

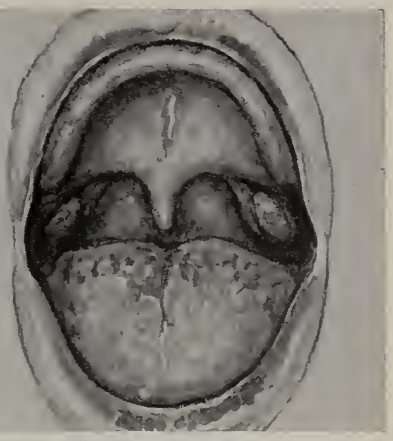


Fig. 6

of or above 1 mv. volts), has to offer as compared to conventional therapy which ranges below 1 million volts and includes the best known machines of this type, the 250 roentgen ray units.

To make the point of disillusionment first: Supervoltage therapy is no miracle weapon; the biological effect is essentially the same as with 250 kv. machines. If, therefore, advantages with the use of these units can be expected, they have to be due to better physical qualities, qualities which are typical for this hard beam of radiation, and these superior physical qualities do indeed exist and they are responsible for the usefulness of the machines. These physical qualities are: better penetration, maximum ionization of the beam of irradiation (not on the surface directly, but 0.4 cm below) diminished scatter, and decreased absorption of radiation in bones and cartilage. All these different physical qualities result in better local and general tolerance to therapy which make it possible to give a higher tumor dose with less damaging side effects.

Due to the fact that the beam of supervoltage radiation has its maximum ionization below the skin, skin reactions are much less severe on the supervoltage units than on the conventional ones. As a matter of fact, they are practically no problem.

The advantages, in short, are: better local tolerance due to less skin, mucous membrane, bone and cartilage reactions, and less of a general reaction due to less scatter of this hard beam of radiation. In other words: a better therapeutic ratio has been achieved.

To come back now to these special patients and the use of 2 mv. irradiation in their particular situation where we had to deliver a large tumor dose through large fields throughout areas where the blood supply was damaged by previous therapeutic procedures. The best possibility to achieve our goal was with the use of a supervoltage unit. Due to the advantages of supervoltage irradiation, as described before, we knew that we would be able to deliver a large tumor dose, large enough possibly to control the disease without damaging healthy tissues beyond repair much less as with a conventional therapy unit.

The patient was outlined to be treated with two million volt irradiation through one left lateral field.

It was our goal to deliver a dosage of 6000r to all of the tumor-bearing areas in the mouth. With that method, the skin of the left side was going to receive a dose of 6850r, the left gum, palate and left side of the tongue 6400r, the midline 6000r, and the right side of the mouth, where less of a dosage was desirable only 3600r, while the skin on the right side received 3000r. This dosage was delivered in six weeks, through a field 8x10 cm in diameter (Figs. 2 and 3).

The treatments were tolerated well. During the third week, a mucositis developed, and the patient complained of soreness in her mouth; however, she was able to eat and maintained her weight during the treatment. Except for an erythema on the left side, there was no skin reaction present. The result of therapy was most satisfactory. The lesions healed and the mucous membranes looked normal after the mucositis had subsided. During the first year after therapy, the patient complained of dryness of the mouth. During the second year, the dryness subsided, and the patient felt well. Her skin appeared completely normal, the film of the mandible showed no changes, and, most important, there was no recurrence. Today, six years and nine months after

The Author

RUTH GUTTMANN
M.D.



therapy, there is still no change in skin and bone. The mucous membranes have a moist glistening surface, and there is no evidence of disease (Figs. 4, 5 and 6).

the management was. Management and diagnosis, however, were a problem in some of the patients of the second, but mostly of the third group.



Figs. 7, 8, 9 and 10

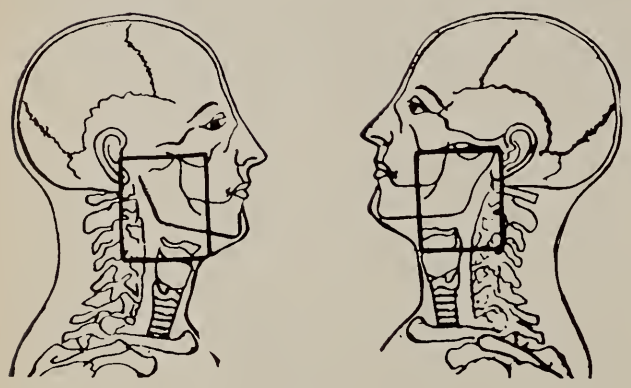


Fig. 11

With conventional 250 kv. therapy, the skin would not have tolerated this amount of radiation, there would have been telangiectasis and fibrosis, maybe even an ulceration. With comparable dosages and conventional therapy there might have been bone necrosis, a danger which is greatly decreased when supervoltage is used because the hard and more penetrating beam of supervoltage irradiation is less freely absorbed by bone and therefore will not give rise to bone necrosis so easily.

The question of diagnosis was no problem here—

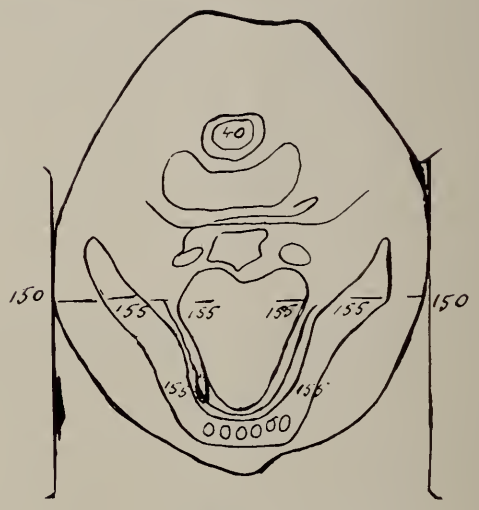


Fig. 12

Group II. Squamous Cell Carcinoma—Non-Adjacent Parts of Oral Cavity

As I mentioned before, most of the six patients belonging to the second group had the causative factor of the disease in common—namely, alcoholism or excessive smoking.

The first patient of this group was a chronic alcoholic, who had consumed at least one quart of whiskey daily for

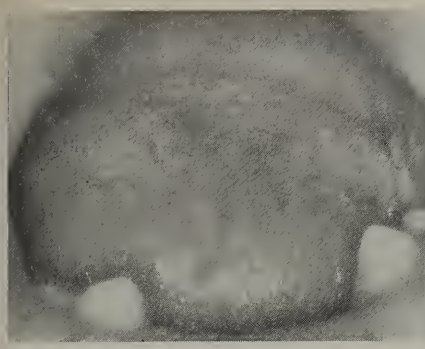


Fig. 13. 2000 kv., opposing ports 9x11 cm.



Fig. 14. 2000 kv., two ports.

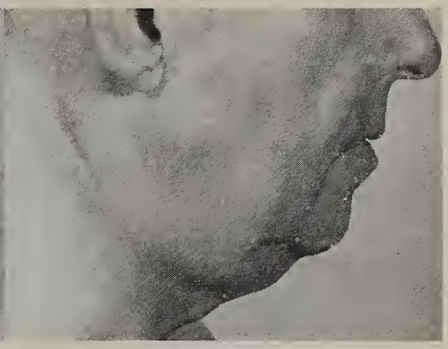


Fig. 15

the last ten years. In 1953, he developed a lesion in the right floor of the mouth, which on biopsy proved to be squamous cell carcinoma. This lesion was treated at that time in another hospital with conventional external irradiation on a 250 kv. unit; a tumor dose of 2500r was delivered through multiple fields. The lesion was thought to be controlled after therapy. One and a half years later, however, the patient was referred to us with a recurrence in the original site and, in addition, with a new lesion in the left tonsillar fossa and base of the tongue and with neck node metastases. On biopsy, both lesions proved to be squamous cell carcinoma (Figs. 7, 8, 9 and 10).

I want to emphasize that here again in the opinion of our pathologists, as in all other patients mentioned in this presentation, two primary lesions existed. The first thought was to ask the patient to submit to radical surgery. This recommendation was motivated by the failure of previous radiotherapy to control the primary tumor; however, with the extensive lesions and the large metastatic neck nodes, the procedure did not seem to promise results. In addition, the patient refused surgery. Irradiation was the only mode of treatment left, and these were the difficulties we had to deal with in this patient: Again a large area, practically the entire oral cavity had to be included in the field of irradiation, an even dosage had to be delivered to all the areas involved and that in spite of the fact that one of these lesions had been treated previously with irradiation.

Again, as in the previous patient, and for the same reasons, we decided to treat the patient with 2 mv. irradiation, but in this case we had to approach the lesion through two opposing fields, as it was necessary to deliver a full dose of radiation through the entire oral cavity as the proved tumors were on the right and left side and to deliver a tumor dose of 6000r in six weeks' time (Figs. 11 and 12). The treatments, though delivered through large fields, were tolerated well. Mucositis and skin erythema developed, but only to a mild degree. The result of therapy was an excellent one, both lesions and the neck nodes disappeared under treatment. No late changes of skin, bone or mucous membranes have shown up (Figs. 13, 14 and 15).

The patient did well for three years after completion of therapy, but developed more disease after that time and died eventually from his disease, four years after we had treated him.

This patient represents an example for excellent palliation. After all, we did see him first with a hopelessly advanced condition, which had been treated previously, and kept him comfortable for four years. Radical surgical procedures are often performed for shorter lasting periods of freedom from disease, and we were able to achieve this goal without the discomfort of a surgical procedure and without the mutilating effect of radical surgery.

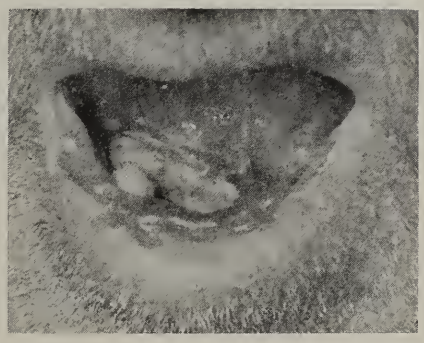


Fig. 16

Another patient who belongs to this group has been treated only recently. He presented himself with the following history: He has been an alcoholic for many years and four years ago needed a laryngectomy for cancer of the left vocal cord which extended to the anterior commissure. He remained well until January, 1960, when at the time of a routine examination two lesions were found in the floor of the mouth, in the sublingual area. A biopsy of both showed squamous cell carcinoma (Fig. 16).

No lympnodes could be palpated. When the question of a proper treatment approach was raised, the possibility of radical surgery was presented to the patient and was refused. He had had already one mutilating surgical procedure, he just had gotten used to his esophageal voice, and he was absolutely unwilling to undergo further surgery. We accepted him for super-voltage therapy and he was treated on the 2 mv. unit through opposing fields with a total *TD* of 5000r. The patient tolerated the treatments without complaints, and did not show any evidence of disease at the end of his treatments. As mentioned before, the patient has been treated only recently, but so far he has been well without any evidence of disease for eight months (Figs. 17, 18 and 19).

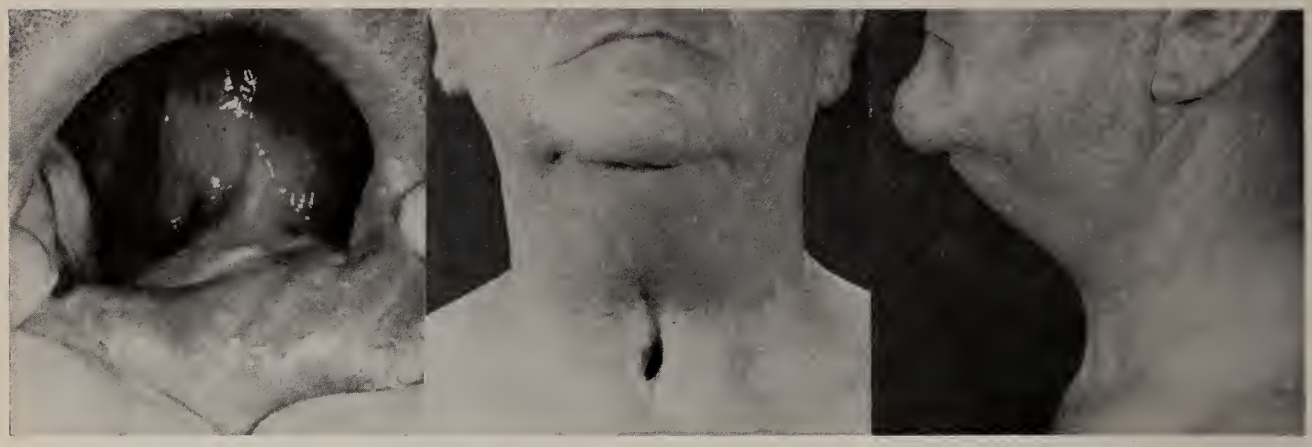


Fig. 17 Fig. 18 Fig. 19

Group III. Squamous Cell Carcinoma in Widely Separated Areas

Now we come to the third group of patients. They represent perhaps the most difficult problems in diagnosis and management of two different primary lesions. Here the importance of a thorough follow-up becomes very obvious, as a good result of previous therapy may be nullified by the miss of the second primary as such. I have nine patients who seem to illustrate my point and I shall discuss two of these.

The first patient was originally treated surgically for a squamous cell epithelioma of the nose. The lesion was widely excised, and plastic surgery was performed. Five years later, the patient developed a large mass of nodes in the neck. The nodes were thought to be metastatic from the squamous cell carcinoma of the nose which had been treated previously as described. As the patient did not have any complaints and was asymptomatic, a radical neck dissection was performed. Plastic surgery was later needed to repair the defect in this region. Two months later, the surgeon found another induration in the scar and then sent the patient to our hospital for further treatment. A thorough examination showed that the patient had an extensive carcinoma of the left side of the pharynx, involving the left tonsillar fossa and extending down below the level of the free margin of the epiglottis. Biopsies showed the lesions to be squamous cell carcinoma.

Without doubt, the positive neck nodes had been due to the intraoral lesions, and the patient had lost precious time by the lack of a proper examination before the neck dissection was performed. Early diagnosis of any malignant disease may improve the chances of a patient's survival, and if it is possible to detect the presence of multiple lesions early, and to bring the patients to definitive therapy, their chances may improve too. For the extensive lesion of this patient, surgery was out of the question, and the patient was accepted for radiotherapy. Here the difficulty was to have to treat the patient aggressively over areas where the blood supply had been drastically changed by previous radical surgical procedures, including plastic surgery.

The patient was treated on the 2 mv. unit through opposing fields for a total TD of 5000r, which was delivered in six weeks. Three months after completion of treatment, there was no evidence of disease. Three years after therapy, the patient still feels well without evidence of local disease. We are reasonably certain that he will have a recurrence sooner or later, but again we know that excellent and long lasting palliation has been achieved in a case with hopelessly advanced disease, which occurred in a patient where radiotherapy was the only possible treatment approach, but where we had to overcome great difficulties because of the previous surgical procedures.

The last patient belonging to this group was treated in our department for a carcinoma which arose in the left anterior tonsillar pillar, extending to the mucosa of the ascending ramus of the left side of the mandible with an ulceration at the base of the tongue. The treatment was carried out with supervoltage therapy, and the patient was treated through two opposing fields on the 2 mv. unit, and 5000r were delivered in five weeks' time. During therapy, the lesion regressed well, the patient had less difficulties in swallowing, less pain. However, seven months after completion of therapy, the patient stated that she again experienced some difficulties in swallowing, but her examination at that time did not show any re-occurrence of the initial lesion. However, a barium swallow and examination of the esophagus showed a lesion in the midesophagus, measuring 8 cm. in length. A biopsy of this lesion showed squamous cell carcinoma (Fig. 20).

We started immediately a course of rotation therapy with another of our supervoltage unit, a Cobalt 60 unit. Again, during the course of therapy, the patient started to improve, and after completion of therapy, she was able to eat normally (Fig. 21).

The patient stayed well for more than one year, when she developed a thrombophlebitis in her leg, which resulted in an infarct of the lung, of which she died, more than two year after she was first treated in our department. The patient died at home and we did not get an autopsy which might have given us important information as to the presence of residual disease.

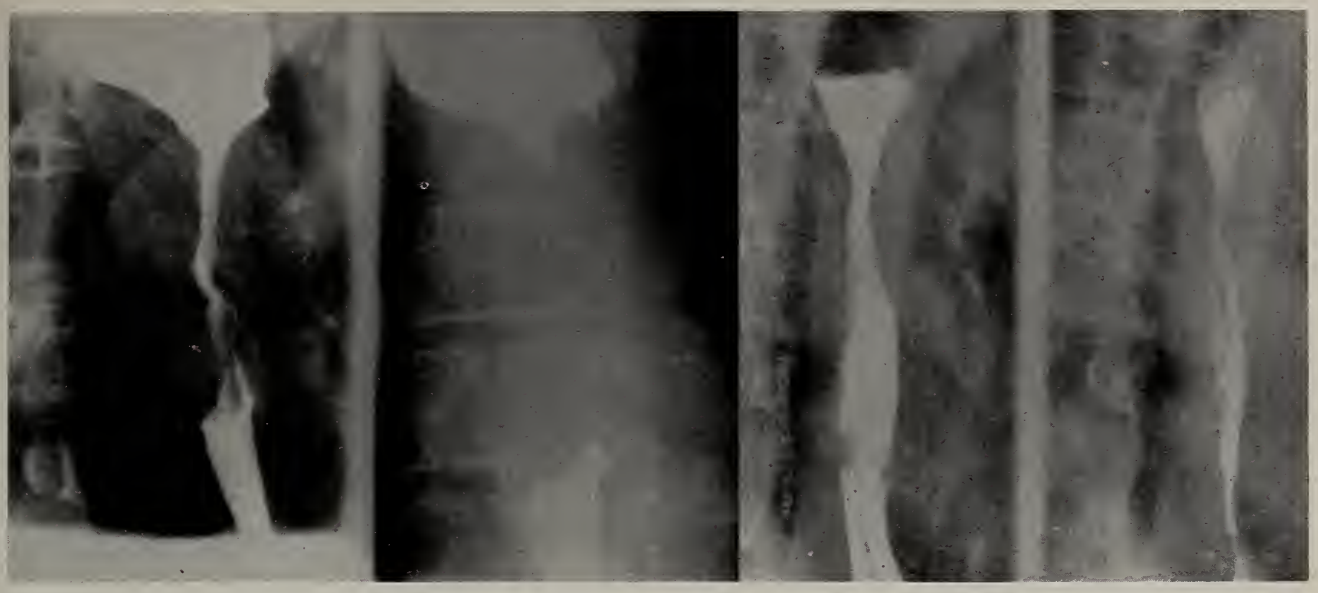


Fig. 20

Fig. 21

Summary

In summarizing, I would like to emphasize that this group of patients was not presented for any statistical purposes or for the discussion of the superiority of one treatment method over the other one. Most of these patients were not treated primarily by us, but were treatment failures and had to be retreated for recurring and new disease. The reasons which made me select this subject, and which, in my opinion, were worth mentioning and of importance, were different ones: They were: (1) to call attention to the not infrequent presence of two primary lesions in the head and neck area in one patient; (2) the possible significance of abundant consumption of alcohol or the excessive use of tobacco in connection with the origin of the lesions; (3) the necessity of most careful and thorough examination of the patient, regardless of the fact that he may be asymptomatic at that time, and the need to follow complaints of the patient very closely and to look for an explanation of symptoms even if they can be partly explained by the previous history; (4) the consideration of the best treatment approach under these circumstances, in these patients who develop carcinomas on top of precancerous lesions, or patients who have a history of alcoholism or excessive smoking.

As these conditions seem to tend to give rise to more than one neoplasm, it would be reasonable to look at such patients with this thought in mind and to plan the therapy approach accordingly, especially when we keep in mind that the first treatment approach is always the most important one, and the second therapist, whether surgeon or radiotherapist, cannot achieve the same beneficial result as the one who treats the patient first. Such patients might benefit more from well-planned and carried-out radical radiotherapy than from radical surgery. The most radical surgical procedure often cannot be radical enough to prevent the occurrence of other cancerous growths and yet will leave the patient mutilated in more than one respect, often unable to make a living, often even unable to continue to live at home.

I have tried to demonstrate that radiotherapy, especially supervoltage radiotherapy, in some of these hopeless recurrent cases, has been able to control the disease for shorter and longer times, for more than six years in one of our patients, in others for four to five years. But even in the instances when patients were comfortable and without evidence of disease for only two or three years, this must be considered to be excellent palliation, as after therapy the patient was not only alive and comfortable, but also able to live a normal life and to continue in his job.

I like to stress that we, who work in a cancer hospital, have learned that while a five-year survival remains our goal, one cannot measure success only in statistics which show such five-year survivals, as excellent palliation for many months and years may bring gains to the patient which cannot be measured in the cold figures of survival time alone.

Treatment of Peptic Ulcer

John B. Gross, M.D.
Rochester, Minnesota

PEPTIC ULCER—a chronic, recurrent, essentially nonfatal but nonetheless potentially disabling condition—is said to affect about 10 per cent of the population in the United States. Untold man-hours of suffering and of absence from work, not infrequently involving key personnel in executive positions, are attributable to peptic ulcer. Although uncomplicated peptic ulcer is not a serious ailment, the complications are sometimes hazardous and life-threatening. In view of these considerations, it is surprising that the medical therapy of peptic ulcer has been somewhat haphazard and casual at times.

Although the term "peptic ulcer" is a convenience, it fails to specify the location of the ulcerative process, and clearly implies benignity of the lesion. For these reasons and because of the possibility that the ulcerating gastric lesion is actually malignant, clinicians usually prefer to consider ulcers of duodenum and of stomach separately.

Duodenal Ulcer

General Considerations.—Each patient with chronic duodenal ulcer represents a therapeutic challenge to the conscientious physician, an opportunity to try one's hand in a game with low entry fee but with great potential benefit for the patient and real satisfaction for the practitioner.

Although effective therapy for duodenal ulcer is not difficult to devise and can be standardized to some extent, such therapy also must be individualized, for no two patients or their life situations are identical. The chief contributing factor in one case may be the frustration of a nagging wife or mother-in-law in the home, whereas for another person irregular hours of eating and long hours of work under tension, combined with fifteen cups of coffee during the day, may be his undoing.

Of the various observations bearing on etiology and pathogenesis of duodenal ulcer, three with practical implications stand out. First, the tendency to duodenal ulcer seems to be inherited in most instances. This observation admittedly explains little but it does serve to emphasize the importance of interval therapy, designed to ward off recurrences. Second, acute exacerbations of duodenal ulcer occur most often under conditions of stress—emotional, physical, or both. Third, whatever other factors make for active duodenal ulceration, free hydrochloric acid elaborated by the gastric mucosa is an essential link in the chain.

Essentials of Successful Medical Therapy.—The patient's full cooperation and understanding are of the utmost importance. With these ingredients success is practically assured; without them, medical therapy is often doomed to failure. There is no substitute for good rapport between patient and doctor. Most ulcer patients appreciate the physician who takes time to share with them something of his knowledge and experience pertaining to the natural history and management of chronic duodenal ulcer. To be informed that the lesion is not malignant nor likely to become so usually is reassuring; many patients seem to have entertained this fear.

Willingness to Modify Habits.—Generally it is of definite advantage to the ulcer patient to effect cer-



The Author

JOHN B. GROSS
M.D.

Read at the meeting of the Michigan State Medical Society, Detroit, Michigan, September 27, 1960.

From the Section of Medicine, Mayo Clinic and Mayo Foundation. The Mayo Foundation, Rochester, Minnesota, is a part of the Graduate School of the University of Minnesota.

tain changes in his mode of living, forsaking all that contributes to a harried existence, and in addition foregoing alcohol, caffeine, spices, and tobacco—those minor indulgences which his friends seem able to enjoy without particular harm. Regularity with regard to habits of eating and sleeping is most helpful. Learning to say "No" is difficult for many, but is a real asset.

Rest.—Every physician knows at least one patient who can heal his duodenal ulcer by taking off on a fishing trip. The efficacy of mental and physical rest is doubtless one factor which contributes to the striking effect of a strict medical regimen for ulcer carried out with the patient in the hospital.

Control of the Acid Factor.—The dictum, "No acid, no ulcer," has stood the test of time. The cornerstone of the medical program for peptic ulcer is effective control of hyperacidity. The present-day antacids, if not ideal, are clinically effective and also relatively inexpensive. Most are compounded of aluminum hydroxide and magnesium trisilicate or hydroxide. Exchange resins and other acid-neutralizers have not proved to be any more advantageous than the more conventional antacids. Long-term use of absorbable antacids is to be avoided, of course. Antichlorinergics, designed to reduce hydrochloric acid output and pyloroduodenal spasm, are rational and helpful adjuncts.[3]

Concept of an Ulcer Program.—We physicians may be partly responsible for the fact that most ulcer patients tend to equate diet with medical therapy. Avoidance of gastric irritants and potent acid secretagogues in the diet is important, of course; but many with peptic ulcer need to understand that reduction of tension factors, adequate rest, and effective control of hydrochloric acid are probably just as important. Experience has taught the wisdom of stressing to patients the concept that the medical treatment of ulcer is a *program*, one that should be followed, in greater or lesser degree, indefinitely.

Regimen for Active Duodenal Ulcer.—Most patients with uncomplicated active duodenal ulcer can be treated satisfactorily on an outpatient basis, although a brief period of hospitalization often is helpful initially. Having the opportunity to rest in the hospital and to experience a strict ulcer regimen usually serves to orient the patient more effectively than if he is only told what is advisable in regard to ulcer therapy.

Rest and Sedation.—During the active phase, patients do better to spend much of the day resting in bed, away from telephone, business cares, visitors, and other sources of tension. Sometimes they are loathe to accept the idea that vegetating will promote earlier healing of the ulcer. Now is the time for *Pickwick Papers* or *The Caine Mutiny* or some equally absorbing book. Small doses of some sedative—for example, one-half grain of phenobarbital four times daily—facilitate emotional and physical rest. Ordinarily tranquilizing agents are not necessary. As the pain subsides, the patient can resume activity gradually, although it is well to point out to patients that the ulcer will not have healed over completely for a week or more after the pain has subsided. Delaying return to work for a week or two is usually worth while.

Diet.—There is no one road to success diet-wise. The conventional strict ulcer regimen begins with hourly feedings of 3 or 4 ounces of whole milk or equal parts of milk and cream taken throughout the day, and sometimes to advantage several times during the night as well. Few with uncomplicated duodenal ulcer need remain longer than a day or so on such a strict diet; soft, bland foods, such as creamed soups, puddings, mashed potatoes, and the flesh of chicken and fish or lean beef, can be added rather quickly, as tolerated. Recent study of responses in the dog suggests that some revision of our dietary concepts in the treatment of peptic ulcer may be forthcoming one day.[7] Interestingly, of the foods tested, haddock was the most potent in stimulating acid formation, whereas fruits were among the least acid-provoking; milk was moderately secretagogic, an observation difficult to reconcile with clinical experience.

Antacid.—The liquid form of any of the nonabsorbable antacids is slightly more effective than the tablet form. When the ulcer is active, one half to one tablespoonful of such a preparation is taken each hour throughout the day. A satisfactory plan initially is milk feedings on the hour, and antacid hourly on the half hour. Patients sometimes indicate that at the outset the details of such a program are confusing, in which case it may be pointed out that the main objective is to put milk, antacid, or bland food into the stomach every half hour or so all day long. Hospitalization for institution of a strict ulcer regimen is attended by less confusion or misunderstanding about details of the ulcer program, although the observations of Roth and Berger indicate that, even in the hospital, patients with peptic ulcer may take less than

half the amount of antacid prescribed, for reasons not entirely clear.

Anticholinergic Medication.—Although it probably is not possible to effect achlorhydria through the entire twenty-four hours by means of anticholinergics in doses tolerated, these drugs do interfere to some extent with secretion of hydrochloric acid by the gastric mucosa and also inhibit gastrointestinal motility. Most patients with duodenal ulcer seem to benefit from addition of some preparation such as propantheline (pro-banthine) bromide to their program, in a dosage of 15 mg. four times daily by mouth.

The Liberal Ulcer, or Interval, Program.—Like the proverbial hen's tooth is the ulcer patient who has grasped the concept of interval ulcer therapy; but it would be a naïve and unwarranted assumption that such had never been outlined for the others. At times in the past it has been both surprising and disappointing to have patients inquire how long they were to remain on the liberal ulcer program, when it had been explained carefully only a month or two previously that they were to stay on the program permanently, or until such time as an actual or anticipated return of ulcer pain necessitated reversion to a more strict program.

Evidently this is a concept which is quite difficult for many with ulcer to understand and to accept. It is helpful to emphasize the goal of *control* rather than *cure* of peptic ulcer, likening the condition to other chronic afflictions, such as pernicious anemia, tuberculosis, or chronic ulcerative colitis, and stressing the apparently inborn and lifelong tendency toward recurrent ulceration. Patients who appreciate the advantages of staying on a liberal ulcer regimen and who conscientiously follow through with it do seem to benefit, in general, by having fewer recurrences and complications of ulcer. Some patients understand but are unwilling to make more than token modifications in their living habits; and when ulcer pain recurs, the antiulcer measures employed are often too sparing, an ineffectual response to the problem which might be categorized as the "barn-door phenomenon."

As the ulcer distress subsides, the patient gradually can resume a more normal existence. As his activity is increased, the diet is liberalized also; only spiced, greasy, and otherwise indigestible foods are omitted. Alcohol, caffeine, and tobacco should be totally and permanently avoided, however. It is enough ordinarily to take antacid 1 to 1½ hours before meals and the same period after, and at bedtime; but this practice should be continued indefinitely. Most patients during the symptom-free intervals of months or years do not require sedative or anticholinergic medications except at infrequent and special times.

It is advisable for some patients, particularly those who have experienced regular seasonal recurrences of active ulcer, to revert to the more strict ulcer regimen a few weeks prior to the anticipated flares. Such prophylaxis seems to work well for many.

Management of Ulcer Complications.—

Hemorrhage.—Although some patients with peptic ulcer never do develop complications, others are less fortunate. Approximately 40 per cent of those with duodenal ulcers in my own practice have experienced one or more episodes of hemorrhage; in perhaps 10 per cent bleeding has been the initial symptom. An episode of hemorrhage does not per se necessitate operation unless it is massive or prolonged. It is usually preferable to hospitalize the actively bleeding patient for management, however. Adequate and early replacement of blood by transfusion is generally acknowledged to be the most significant development in recent years in managing the bleeding ulcer patient successfully. Another factor which seems to be of real importance is adequate sedation; 2 or 3 grains of phenobarbital sodium (luminal sodium) given hypodermically every three to six hours is satisfactory for most patients. Nausea and vomiting are best managed by constant suction via an indwelling gastric tube, which also serves to introduce a half ounce of antacid hourly. In addition, intravenous fluids calculated to replace losses of water and electrolytes should be given.

If bleeding continues after the first eighteen to twenty-four hours in the hospital, operation should not be delayed, unless the patient's physical condition otherwise precludes it. The patient with actively bleeding peptic ulcer is best managed by physicians and surgeons as a team from the time he is hospitalized. In this way subtle changes in the patient's condition during these critical first twelve to twenty-four hours are appreciated best. The surgical procedure of choice depends on the clinical condition and age of the patient, as well as the situation encountered at operation. When bleeding is profuse, most surgeons elect only to tie off the bleeding vessel and oversew the area rather than to add to the duration and risk of the procedure by performing subtotal gastrectomy or even gastrojejunostomy at that critical time. This decision, of course, is a matter of surgical judgment.

Gastric resection is not indicated for the relatively

young patient with a history of brief melena on one occasion (or even two) unless adequate, conscientious trial of a good medical program has proved truly ineffectual.

Obstruction.—Pyloroduodenal obstruction is a common complication of duodenal ulcer. The cardinal sign of significant obstruction is retention-type vomiting. Ordinarily when there is a history of emesis containing food remnants from the previous day, operative intervention will be required in the near future. Such obstruction usually results from cicatricial narrowing of the duodenum, with spasm and edema of the duodenum and pylorus superimposed. If the patient is seen during the first such obstructive episode, almost always with strict ulcer management the spasm and edema will subside in a few days, so that the obstruction relents. Aspirations of the stomach morning and evening then no longer return the 300 to 500 ml. of retained fluid originally obtained each time. Although at this juncture the patient may elect to continue with a medical regimen, and although gastric resection cannot be urged, for most such patients the handwriting is on the wall, so to speak—most will come to operation within a year or so.

Attention must be given to replacement of water and electrolyte losses resulting from continued vomiting and gastric aspirations. Patients with high-grade obstruction may require several days of preoperative preparation including daily intravenous administration of 3 to 6 liters of fluid, with special regard for restoration of potassium and chloride. Urinary output and daily determinations of serum potassium and plasma chloride values are useful guideposts during this period of preoperative care.

Intractability.—In discussions of the intractable ulcer, one frequently hears the comment that there is no such condition—that it is the patient who is intractable! Often it seems that this is true, although one does encounter an occasional patient who has followed a strict medical regimen conscientiously without being able to control the ulcer. Sometimes over a period of years there is a gradual increase in the frequency and duration of exacerbations until pain is present most of the time, signifying penetration of the ulcer into the surrounding structures. From the practical standpoint, whether the recalcitrant is the patient or the ulcer, the end result is the same: lack of success with medical measures. In such cases subtotal gastrectomy is usually the advisable course.

Sometimes it is necessary to treat penetrating duodenal ulcer despite the presence of other serious organic disease, such as severe coronary sclerosis, brain tumor, disorders of blood coagulation, and so on, which tends to make the risk of operative intervention prohibitive. If in such cases thorough trial of the more conventional strict ulcer program proves inadequate, roentgen therapy can be a most helpful adjunct.[2] Radiation directed to the stomach apparently can effect at least temporary achlorhydria in many persons so treated and has induced gratifying remissions of ulcer in some of our own poor-risk patients so treated.

Perforation.—The dramatic occurrence of free perforation of an ulcer necessitates admission to the hospital as an emergency. Perforation in almost all instances is treated by prompt surgical closure. The severe pain, rigid abdominal wall, and demonstration of free air in the abdominal cavity leave little doubt concerning the diagnosis.

Some[5] have treated perforated duodenal ulcer successfully by nonsurgical means. However, the technic of constant gastric suction necessitates continuous (around-the-clock) supervision of the tube by one of a team of dedicated and experienced physicians. This method of treatment has not received wide acceptance.

The Ulcerating Gastric Lesion

The term "gastric ulcer" is so firmly entrenched that there appears little likelihood of replacing it with one which seems preferable clinically—"ulcerating gastric lesion." "Gastric ulcer" implies benignity, whereas "ulcerating gastric lesion" is unprejudicial in this regard. The physician faced with the problem of advising therapy for the patient who has been found on roentgenologic study to have an ulcerating gastric lesion realizes that in large series of such cases 90 per cent of the lesions[1,3] are not malignant. The problem, however, is to decide about the nature of the lesion in *this particular patient.*

The most certain identification of the ulcerating gastric lesion is afforded by removal and histologic study. However, subtotal gastrectomy, although excellent treatment for benign gastric ulcer, carries a mortality of at least 1.5 per cent. How accurately can the clinician differentiate benign and malignant ulcerating lesions of the stomach today? No simple answer can be given, because the diagnostic accuracy depends on many factors, variables which must be evaluated for each patient. Such factors as the skill and interest of the physician and his knowledge of the problem; the patient's cooperativeness, understanding,

and financial resources; the availability of important technical helps, such as skilled roentgenologic examination, gastroscopy, gastric cytologic study, and gastric analysis—all enter into the decision about medical versus surgical treatment in the individual case.

The help which the special laboratory procedures can provide is largely dependent on the care with which they are conducted, as well as the experience and technical skill of those charged with their performance. Gastroscopy has been of only limited value in this difficult decision about benignancy versus malignancy. The relatively new technic of exfoliative gastric cytology in experienced hands has been helpful, both in a positive way and negatively.[5] However, none of these procedures can be relied upon exclusively or trusted implicitly.

In many cases the decision for surgical intervention is not difficult. There is general agreement that operation is indicated when any of the clinical evidence suggests malignancy. When all signs point to benign gastric ulcer and when the patient elects this course, a brief, closely observed trial of a strict medical program is justifiable.[3,4] Such treatment is best conducted with the patient in the hospital and for a limited period of two to four weeks. If repeat roentgenologic examinations show satisfactory progression to healing and—after the patient's discharge from the hospital—continued absence of the lesion over the next year, the asymptomatic patient no longer need be observed. In such cases the importance of roentgenologic studies of the stomach every 2 to 3 months during the first year cannot be overemphasized, since ulcerating malignancy occasionally will appear to respond initially to medical therapy.

It is apparent that the choice of therapy for the ulcerating gastric lesion must be weighed carefully for each individual patient. Considering all available evidence in each case, my associates and I have advised operative intervention for 60 to 70 per cent of patients with ulcerating gastric lesions in recent years. Some 10 per cent of these lesions have proved to be malignant.

Concluding Remarks

The vast majority of patients with uncomplicated chronic duodenal ulcer are able to get along well on medical measures aimed at control of gastric acidity. Such a medical program embraces adequate rest and reduction of emotional tension, a bland diet, frequent and regular use of a nonabsorbable antacid, and anticholinergic medication. The importance of continuing a liberal ulcer regimen during the symptom-free intervals between recurrences of active ulceration has been inadequately appreciated by many patients. The wise ulcer patient avoids totally and permanently the use of alcohol, caffeine, and tobacco.

The complications of duodenal ulcer usually necessitate surgical intervention sooner or later. Subtotal gastrectomy is still the operation performed most often for duodenal ulcer, except in the emergency situations of massive hemorrhage and free perforation. Roentgen therapy to induce gastric achlorhydria is a useful adjunct in the seriously ill patient with penetrating duodenal ulcer which has not responded to more conventional medical measures.

The ulcerating gastric lesion is a separate problem because of the possibility of malignancy. Choice of therapy is a highly individual matter, influenced by a number of variables. If thorough clinical study discloses no evidence to suggest the presence of malignancy, a so-called medical therapeutic trial of two to four weeks in the hospital is justified, although many such patients do not get along well for long on medical therapy and eventually, if not early, will elect to proceed with surgical exploration and subtotal gastrectomy, results of which are generally very satisfactory.

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Management of Diverticulitis Of the Colon

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DURING the past twenty years, profound changes have occurred in the medical and surgical management of problems relating to diverticulitis of the colon. In comparison to some other diseases of the gastrointestinal tract, there seems to have been an inexplicable lag in the application of modern medical measures to the relief of this particular disease; and it is only relatively recently that contemporary concepts and techniques have provided definitive therapy. Those factors which might be considered to have favored this more effective approach to the problems of diverticultis include the increasing frequency of the disease in an aging population, a better understanding of its natural history, a clearer appreciation of the severity of its complications, and finally a very definite improvement in the surgical handling and operative mortality over the past ten to fifteen years. These factors will be considered in further detail.

Illustrative Cases

Case 1.—Twenty-three years ago, J.M., a physician, was admitted to the Massachusetts General Hospital with acute lower abdominal pain, dysuria, midline mass, fever, and leucocytosis. He was only forty years old, and at the time had a six-year history of recurrent attacks of acute diverticulitis, several times demonstrated by x-ray. In spite of a febrile course and partial intestinal obstruction, he was treated expectantly. On the fourth hospital day a small abscess in the left lower quadrant was drained, and on the tenth day, because of persistent obstruction, a cecostomy was performed. This proved ineffectual in decompressing the intestine, and on the twenty-third day, a transverse colostomy was established. Subsequently, he improved rapidly and returned home after ten weeks of hospitalization. Prior to discharge a barium enema was done and numerous diverticula were found in the descending and sigmoid colon, with marked spasm and irregularity at the midpoint of the latter. No barium was noted to extravasate extraluminally, and it was felt that no gross cavity or fistula to urinary bladder existed.

Six months later, after having returned to work and having been free of bowel complaints, he returned to the hospital where, following a preliminary barium x-ray (which showed only a few diverticula and complete absence of spasm in the bowel), his colostomy was closed, re-establishing normal intestinal continuity.

Then followed a six-year interval during which he remained on a strict medical regime and was able to practice medicine. However, in 1943 an acute bout of abdominal pain resulted in his return to the hospital where the transverse colostomy was re-established. X-rays of the colon again demonstrated many diverticula and severe spasm in the mid-sigmoid. The colostomy functioned well and he was discharged symptom-free. Some months later he unfortunately met a traumatic accidental death.

Case 2.—L. McK., a thirty-five-year-old fireman, entered the same hospital in May 1960. He emphasized that his bowel habits had always been perfectly regular all his life. At age twenty-eight, he had had an appendectomy. On the morning of entry, while at work and some hours following a normal bowel movement, he noted the sudden onset of lower abdominal pain, necessitating hospitalization. Physical examination and laboratory studies were consistent with an inflammatory process in the left lower quadrant, and his condition warranted conservative observation. Three days later a mass could be felt in the left mid-abdomen, and later a carefully administered barium enema revealed moderate spasm of the sigmoid colon and only a few diverticula. One of these in the upper sigmoid had perforated and barium was found to have extravasated into a localized abscess cavity. After twelve days of hospitalization the mass could no longer be felt, the patient was asymptomatic, and he was discharged on a medical regime. At the age of thirty-five, with regular bowel habits, and only a few diverticula, it was believed that medical management was indicated. Even though a perforation had occurred, the resulting abscess had satisfactorily resolved.

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However, on the day following his return home, and again after a normal bowel movement, abdominal pain again was noted, and on admission, a mass could again be felt. One week of hospitalization resulted in the disappearance of all symptoms and the mass. At discharge on this occasion, however, arrangements were made for re-admission in three months, with the hope that a primary resection and anastomosis of the left colon might be carried out.



Fig. 1. *(Left)* (Case 2, L. McK., aged thirty-five) Barium enema taken prior to surgery reveals many left colon diverticula, spasm, and a perforation medial to the upper sigmoid. Fig. 2. *(Right)* (Case 2) Barium study following one-stage colectomy showing the shortened colon and anastomosis between splenic flexure and the lower sigmoid.

On return to his home and on a light type of work, he continued to have symptoms referable to the colon, and after only five weeks of preparation, he was re-admitted and underwent an uneventful left colectomy. At operation, the upper 20 cm. of sigmoid was moderately edematous and there was a 4-cm. firm mass in the adjacent mesentery representing the resolving perforation. The entire area could be mobilized, the splenic flexure freed, and an anastomosis made between the distal transverse colon and distal sigmoid where the bowel was completely free of edema. No protective proximal colostomy was thought necessary; and after an uneventful twelve days, the patient was discharged completely relieved of his disease.

These comparative cases are recorded to illustrate some of the changes that have taken place in the concepts of management of a common serious complication of diverticulitis. Each was handled in accepted fashion, based on the understanding of the day; and in the short span of twenty-odd years, one case ended in ineffectual failure, and the latter in a definitive cure.

Of no small importance in fostering this more effective attack on the problems of diverticulitis in recent years has been the increase in frequency and recognition of diverticulosis and diverticulitis in an aging population. While the exact incidence of the disease is impossible to determine from hospital records, it is usually assumed that diverticula are present in 5 to 10 per cent of all individuals over forty years of age. More accurate data on this point will be available from cancer detection centers where long series of asymptomatic patients have been subjected to routine barium enemas. It is generally accepted, furthermore, that the incidence of diverticula is related to the age of the patient; and in our hospital over a twenty-year span, the average age of patients admitted has increased exactly eight years, from 36.5 years to 44.5 years.

In a much-needed study of the natural history of diverticulosis, Horner[1] has documented findings which are pertinent to the problem of diverticulitis. A careful review of 503 cases of diverticulosis revealed that in 95 per cent of these the sigmoid colon was involved, and in nearly 50 per cent the descending colon contained diverticula. Obviously the incidence of diverticulitis is related to the site of diverticula, and it is not surprising that 90 per cent of operations performed because of the inflammatory process deal with the sigmoid or descending portion of the large intestine.

Horner has also demonstrated that the more extensive the distribution of diverticula, the higher the incidence of diverticulitis. When localized to the sig-

moid colon the finding of associated diverticulitis was 14 per cent; when the left colon was involved, the incidence rose to 17 per cent; and if the entire bowel showed diverticula, inflammatory changes were noted in 50 per cent of the cases. There is also a relationship between the extent of diverticulosis in the entire colon and the actual number of diverticula present in the sigmoid. So that it is to be expected that the greater the length of bowel involved with diverticula, the greater the likelihood of sigmoid diverticulitis. From this data it may be concluded that more than the sigmoid colon need not be removed for diverticulitis of the sigmoid simply because there are diverticula in more proximal segments of the bowel.

One further point is made which has a bearing on present-day management and confirms a clinical impression. As with the recurrence rate of duodenal ulcer, the longer patients having diverticulosis are followed, the greater the incidence of diverticulitis. Those patients who were followed for a five-year interval exhibited a diverticulitis rate of 10 per cent, those followed for ten years, a 25 per cent rate, and the group followed up to eighteen years, a 37 per cent incidence. It has been our impression for some time that the patient under fifty years of age who has had symptomatic diverticula will eventually require surgical relief for this disease if followed for a sufficiently long period of time.

A more energetic approach to the problem of diverticulitis has further been encouraged by the increasing effectiveness and safety of surgery in recent years. There has been a gradual lowering of operative mortality for resections of the colon whether done in one, two, or three stages; the consequence of more intelligent bowel preparation, improved anesthesia, the use of effective antibiotics, and the more liberal administration of blood transfusions. Hayden[2] in 1939 reported the Massachusetts General Hospital experience with this disease and found a mortality rate of 44 per cent in those patients treated with surgery of any kind. Of 140 patients observed in the hospital between the years 1911 and 1936, sixty-three were subjected to operation. Five only underwent resection of the diseased bowel, and the remainder were treated by either exploration with or without drainage for perforation, or a decompressive procedure such as cecostomy or colostomy. On occasion, after a period of fecal diversion, a colostomy was closed without resection of the disease. Death occurred either in the hospital or shortly thereafter in twenty-eight patients, and only sixteen of the sixty-three patients subjected to surgery were still living without symptoms of diverticulitis at the time they were followed. In 1942 Smithwick[3] reported a series of seventy-five patients from the same institution operated upon during the preceding fifteen years. A mortality of 12 per cent was found in this group. However, thirty-three of these patients were subjected to resection of their disease with only two operative deaths. Ten years later, with Dr. Arthur W. Allen and Dr. Claude E. Welch,[4] we reviewed 139 operations performed in the intervening ten years, and noted a 6 per cent mortality; 114 patients underwent surgical resection with the hospital death of three patients only. The present series of cases number 323 operations performed since 1942, with a mortality rate of 5 per cent. Of these patients, the diseased segment of colon was resected on 293 occasions and ten patients succumbed in the immediate postoperative period.

TABLE I. DIVERTICULITIS OF THE SIGMOID COLON
Massachusetts General Hospital
Mortality from all Types of Operative Procedures

Years	Author	No. of Cases	No. of Deaths	Mortality (Per Cent)
1911-1936	Hayden	63	28	44
1927-1942	Smithwick	75	9	12
1942-1953	Welch, Allen, and Donaldson	139	8	6
1942-1958	Present series	323	16	5

Complications of Diverticulitis

Surgical therapy may be divided into that done for the complications of diverticulitis, and that carried out for the primary disease itself. Although 67 per cent of the entire group of 293 patients undergoing definitive resection since 1942 were operated upon because of one complication or another, there has been a slow and cautious trend in recent years to relatively more operations being performed earlier for primary diverticulitis. This is the result of a cooperative effort on the part of internist and surgeon in making the much more difficult decision for or against surgery in this latter group. Faced with the more dramatic complications of the disease, the decision is often easy, because the need for surgical intervention is evident and sometimes urgent.

Perforation.—As noted in Table II, perforation of the colon continues to be the most frequent type of complication and remains the most common cause of death from diverticulitis. In many instances, exacerbations of divericulitis are in fact tiny walled-off per-

forations which later, under medical management, drain spontaneously into the bowel again. Even more major extravasations into the mesentery of the bowel or along the lateral aspect of the sigmoid, producing palpable masses, may remain as localized abscesses and

TABLE II. DIVERTICULITIS OF SIGMOID COLON
Massachusetts General Hospital
(1942-1958)
Indications for Resection
(293 Patients)

Indication for Resection	Per Cent of Total
Complications of diverticulitis	
Perforation	29
Fistula formation	12
Obstruction	18
Bleeding	8
Diverticulitis	33

Preoperative diagnosis of cancer in 15 per cent of total.

eventually resolve into the intestinal tract again. A short period of observation is warranted in such instances in the hope of offering the patient a definitive resection at a later date, rather than immediately embarking on the first stage of a lengthy and cumbersome three-operation type of procedure. Should the inflammatory mass persist or the perforation be free into the peritoneal cavity, the surgery must be radical. An adequate incision for exploration is necessary because of the fact that the diagnosis must be confirmed and a perforated appendix or cancer of the colon not overlooked. Furthermore, any procedure that is carried out should provide a step toward the ultimate excision of the involved segment of colon. A generous lower abdominal incision for exploration, identification of the disease and site of perforation, drainage of the area often by stab-wounds, and a concomitant right transverse colostomy through a short transverse incision is usually possible even in the sickest of patients. Attempt at closure of the perforation is not warranted in the presence of edema, and the colostomy should be fashioned to completely defunction the diseased segment of bowel. Exteriorization of the point of perforation is often most difficult because of thickening and foreshortening of the mesosigmoid and the gravity of the operation is rarely lessened by attempting this maneuver.

Fistula formation between colon and bladder, vagina, small bowel, or ureter is not uncommon and nearly always requires resection of the colon. Most of these individuals have experienced a long period of symptoms referable to diverticulitis before signs of an established fistula insidiously appears. From a technical viewpoint, these patients may be handled by a one-stage resection often, and a safe anastomosis can be satisfactorily performed. However, in the presence of a fistula which has recently developed and about which active inflammation exists, a preliminary transverse colostomy, or certainly a complementary colostomy is a worthy safeguard to the colo-colostomy anastomosis. Cecostomy has no place as a "defunctioning" maneuver in the surgery of diverticulitis.

Obstruction by protracted cicatrization of recurrently inflamed tissue is a common complication of this disease and is usually found in the older age group of patients. All layers of the bowel wall become thickened and fibrous. Usually, after some weeks of intensive dietary supervision and bowel regulation with drugs, much of the edema proximal to the obstruction can be eliminated and a primary resection and anastomosis will be found a technically safe procedure. Again, the exploration must be sufficient to assure the surgeon that he is not dealing with a malignant tumor, a much more common cause of sigmoid obstruction and one which requires a more extensive resection. Should proximal transverse colostomy be necessary because of the degree of obstruction and inflammation, resection of the involved segment is done within two or three weeks if the differential diagnosis is at all in doubt. On the other hand, if diverticulitis is clearly evident, it is preferable to wait for at least three months before a definitive resection is performed.

Hemorrhage.—Massive hemorrhage from diverticulitis is not as rare as once believed, and bleeding of any degree has been found in recent years to be very common. Erosion of vessels at the ostea of diverticula in most instances is secondary to the inflammatory process. In the series of cases reviewed, 24 per cent of patients who were subjected to surgery exhibited some amount of blood in the stool, and a similar frequency has been found by LeRoyer and White,[5] Young and Young,[6] and other observers. It is obvious that bleeding of any type should be ascribed to colon diverticula only after other more common causes of melena have been excluded by x-ray study. Even at laparotomy, the bleeding point can rarely be ascertained and the surgeon must resect what he believes to be, rather than what he knows to be, the offending area of bowel. The dilemma is not clarified by the pathologist in most instances, because he can practically never identify an eroded mucosal vessel in the specimen; and final judgment as to the efficacy of the operation must await the passage of

time and observation for further bleeding. Fortunately most blood loss from diverticula is relatively minor and once the diagnosis is fixed to such a source by repeated barium enema, sigmoidoscopy, and gastrointestinal serial x-ray, these individuals may be carried safely on a medical regime indefinitely. Twenty-three patients in the present series were resected primarily for bleeding, and only in ten was the hemorrhage termed massive. Resection of the bowel is obviously imperative, and it is usually well to protect the anastomosis by a concomitant transverse colostomy because of the emergency procedure performed through an unprepared bowel containing feces and decomposing blood.

Suspected Cancer.—In this series of 293 resections of the colon, the diagnosis could not be clarified by non-operative methods in forty-four instances, and surgery was undertaken in part because of the suspicion of a malignant bowel tumor. Repeated barium enema study, sigmoidoscopy, and even palpation of the bowel wall itself is notoriously misleading; and as Pemberton[7] has indicated, the final diagnosis often cannot be made until the pathologist has opened the bowel in the laboratory. Approximately 10 to 12 per cent of patients with carcinoma of the sigmoid also harbor diverticula; although the coexistence of cancer and diverticulitis is quite rare. The ultimate decision as to the probable diagnosis which in turn will guide the proper timing of the proper operation, hinges on the clinical judgment of the surgeon. A high degree of suspicion of the presence of malignancy should be engendered by the finding of obstruction, repetitive rectal bleeding, atypical radiologic findings, failure to respond to medical therapy, rectal tenesmus, mucus and blood after a preliminary transverse colostomy and, finally, the observation of suspicious cells in the rectal washings.

Primary Diverticulitis

As with other recurrent inflammatory processes, it would be ideal to eliminate the primary disease of diverticulitis prior to the development of such complications as perforation, obstruction, fistula formation, et cetera. This is obviously impractical at the present time, but considerable progress has been made in the past ten to fifteen years in the prophylaxis against these often serious and occasionally fatal sequelae. In Hayden's review of the earlier series of 140 cases at the Massachusetts General Hospital, it was found that in all sixty-three of the patients subjected to surgery, operation was necessary because of some complication of the disease, usually a perforation or obstruction. In the more recent group of 1118 patients observed in this hospital from 1942 to 1958, 323 patients underwent surgery, and only 67 per cent of these operations were performed for complications, the remainder being performed for primary diverticulitis. It is evident that the selection of patients with uncomplicated diverticulitis for surgery has been a subject of growing importance in recent years.

TABLE III. DIVERTICULITIS OF SIGMOID COLON
Massachusetts General Hospital
(1942-1958)

	Total Cases	Died	Per Cent
No operation	795	7	1.0
Laparotomy only	12	1	8.0
Colostomy or cecostomy only	18	5	28.0
Resection in 1, 2, or 3 stages	293	10	3.4
Total	1118	23	2.1

To foretell which patient with uncomplciated diverticulitis will do well on a medical regime is as difficult as with duodenal ulcer. It is apparent that in most instances this decision can be made only after following the individual patient for some length of time. And the observation of Horner that there is a striking relationship between the length of follow-up of these patients and the subsequent incidence of diverticulitis is of particular interest in this regard. A similar conclusion was reached by Moore and his co-workers[8] several years ago in their follow-up of a large series of patients with duodenal ulcer in our institution.

It is generally agreed that the great majority of patients with uncomplicated diverticulitis, exhibiting relatively minor symptoms will continue to be successfully treated by medical measures. Of the 1118 patients hospitalized for all forms of the disease, between 1942 and 1958, approximately 70 per cent were discharged on a medical regime. And, of course, many other milder cases were treated in the medical clinic and in private offices. Those patients with intermittent attacks of diarrhea or constipation, with transient lower abdominal pain, bloating, and tenderness can generally be followed in the out-patient clinics. Such symptoms respond well to a low roughage diet, atropine, metamucil, or mineral oil, and occasionally sulfonamide drugs. In establishing the diagnosis by x-ray study, the instillation of barium into the various diverticula has, in the past, been considered to be of therapeutic value.

In rare instances, the acute symptoms are of serious enough import to indicate immediate early surgery. Often a single episode of diverticulitis may be followed by others in rapid succession; or there may be a period of freedom from recurrence for many

TABLE IV. DIVERTICULITIS OF SIGMOID COLON
(1942-1958)
Type of Resection and Mortality
(293 Resections)

Type of Surgery	Total Cases	Deaths	Mortality (Per Cent)
Single stage	143	6	4.0
Multiple stage	146	4	2.6
Miscellaneous	4	0	0.
Total	293	10	3.4

months. Thus, it is impossible to state emperically that one, two, or three attacks of acute diverticulitis, each with left lower quadrant pain, tenderness, fever, and leukocytosis, is indication for surgery. As in the case of duodenal ulcer, the aid of a respected consultant should often be sought. With some reservations those patients who may be considered, in the absence of serious contraindications, to be suitable candidates for early definitive surgery may be classified as follows:

1. Patients who continue to have attacks of pain, tenderness, fever, with or without a mass, on a good medical regime. Two or more such attacks, occurring weeks or months apart in a patient who is otherwise in good physical condition, should in general be an indication for surgical removal of the disease when it is in a quiescent phase.

2. Younger patients, particularly under fifty years of age, who develop diverticulitis should be offered surgical resection. Life expectancy in this group is long, the disease tends to be more severe than in older patients, and the complications which develop late in life are particularly serious. It is wise to perform resection while the patient is young and in good condition.

3. Recurrent rectal bleeding while on a medical regime, particularly when accompanied by worrisome changes in bowel habits, or mucus. Resection should not be delayed in this group because of the blood loss and because roentgen and sigmoidoscopic examinations are not infallible diagnostic tools.

4. Patients demonstrating narrowing, angulation, and fixation of the bowel as indicated by x-ray and proctoscopic examination. Major organic changes rather than spasm are present and further fibrosis threatens obstruction.

5. Urinary symptoms associated with attacks of diverticulitis are of serious significance, particularly in the male patient. Frequency and dysuria may give a premonitory warning of the development of sigmoid-vesical fistula, so often insidious in appearance.

6. In those individuals who have a short segment of colon severely involved, and normal-appearing bowel by x-ray in the areas of the projected anastomosis, it is reasonable to consider early resection. On the other hand, it is logical to extend the period of medical observation in the patient who has numerous diverticula scattered throughout the colon and into the recto-sigmoid area, particularly if he is obese.

Surgery performed at this stage of the disease may be considered prophylactic—and indeed it is, because it is intended to forestall the development of the ever-serious complications of diverticulitis. But an added benefit lies in the type of operative procedure that can be safely carried out. Often it is possible to resect the diseased area of colon completely and perform an anastomosis between the two ends of bowel rather than resorting to the cumbersome and time-consuming two-stage or three-stage operation with its unpleasant transverse colostomy. Here again, a difficult decision must be made as to whether or not a primary bowel anastomosis can safely be done—a conclusion that can be reached only at the operating table itself. The absence of edema and a bowel wall which can hold sutures suitably are the *sine qua non* of a secure anastomosis. It must be remembered that the surgical manipulation of edematous tissue may easily result in thrombosis of microscopic vessels and later postoperative necrosis of the tissue which they nourish; and the consequence of dehiscence of the suture line, in the absence of a proximal colostomy, are always serious—invariably requiring further surgery, and it may be fatal. Three of the six deaths in a group of 143 primary resections in our series of patients were due to this detail.

It cannot be too strongly emphasized, in suggesting early, single-stage resection, that leakage of the suture line poses the greatest single hazard to this operation; and serious sequelae can be practically avoided by the simple maneuver of providing a protective transverse colostomy concomitantly at the time of surgery. It behooves the surgeon when there is the slightest doubt as to the integrity of the bowel anastomosis, to muster his courage and establish a proximal temporary colostomy, distasteful as it may be. Multiple operative

procedures, in our series of patients during the past sixteen years, whether done in two or three stages, carried a slightly lower operative mortality than the one-stage operation.

In spite of this fact, the single operation in this hospital has found increasing favor in recent years. A number of factors have been responsible for this trend. First, the selection of patients for surgery has changed in that they are now operated upon earlier in the course of their disease, prior to the development of extenuating complications. There has also come about, as the result of greater experience in the operative handling of this disease, an improvement in understanding and judgment in the timing of the performance of the definitive surgery. More often, at laparotomy, the bowel is found suitably free of inflammation so that a safe anastomosis can be executed without the aid of a colostomy. Finally, the effective improved facilities available to present-day surgery generally have played no small part in encouraging surgeons in this trend. And as a result, in the more recent years it has been found feasible to manage 75 per cent to 80 per cent of patients undergoing resection by a single-stage operative procedure.

Summary

The drastic changes that have taken place in the management of diverticulitis of the colon in the past twenty years are due to several factors. Greater longevity has increased its frequency in the population, its natural history is now better understood, there is greater appreciation of the seriousness of its complications, and finally, there has been a steady lowering of the operative mortality and morbidity resulting in more effective surgical treatment. Approximately 70 per cent of those patients hospitalized for this disease may be successfully treated by medical measures. In about two-thirds of those patients subjected to surgery today, the operation is necessary for the treatment of one of the several complications of diverticulitis—perforation, fistula, obstruction, or hemorrhage. There is some increase in the relative frequency of operation for the uncomplicated primary disease of diverticulitis—often a difficult decision to make. As a corollary to this, it is becoming increasingly feasible to resect the diseased area and perform the anastomosis in one stage. The value of a protective complementary transverse colostomy in those cases where there is any question of the competency of the suture line in the bowel cannot be over-emphasized. Surgery for diverticulitis of the colon and its complications can now be done with about as great a degree of safety as for any other type of bowel disease. And the long-term results following successful resection of the sigmoid for diverticulitis are excellent.

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The five-year survival rate for cancer of the colon following resection is between 50 and 55 per cent.

* * *

The earliest symptom in cancer of the colon is change in bowel habits, i.e.: increasing constipation often changing to diarrhea and occasionally shifting back and forth.

About half of the malignant lesions in the colon and rectum are located distal to the rectosigmoid junction. Of the other half, 18 per cent are in the descending, 6 per cent in the transverse, and 12 per cent in the ascending colon.

* * *

Obstruction is more common in malignant lesions of the left colon.

Spontaneous Tendon Rupture and Cervical Vertebral Subluxation In Patients with Rheumatoid Arthritis

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THE PAST LITERATURE concerning spontaneous tendon rupture largely relates this condition to trauma. However, recent years have seen increasingly frequent reports of this phenomenon complicating rheumatoid arthritis. In the belief that the resultant disability will be mitigated by earlier recognition and diagnosis and by prompt institution of appropriate treatment, the clinician's attention is directed to the following review of the literature on this subject. An additional fifteen patients are described with rheumatoid arthritis and tendon rupture; in these individuals the frequent coexistence of cervical vertebral subluxation is stressed.

In 1940 von Stapelmohr[1] analyzed 148 cases of extensor pollicis longus tendon rupture; there was one patient in his series in whom it was presumably associated with rheumatoid arthritis. Subsequent publications included sporadic case reports[2-4] and small series of patients.[5-9] More recent descriptions, [10-12] based on larger numbers of patients, suggests this complication is more common than previously realized, a fact emphasized by our own experience. Fifteen patients with various tendon ruptures complicating rheumatoid arthritis have been seen in the recent past by members of The Rackham Arthritis Research Unit and the Department of Orthopedic Surgery at The University of Michigan. In this group there was a total of thirty-eight tendon ruptures (Table I): eleven patients displayed multiple tendon ruptures and in five individuals there was bilateral hand involvement. In ten of eleven patients in whom cervical spine roentgenograms were available, atlanto-axial subluxations were found suggesting incompetence of the transverse ligament responsible for normal atlanto-axial alignment. In five of these individuals multiple cervical vertebral subluxations were demonstrable.

In the available literature[1-10] forty-five selected patients representing seventy-nine tendon ruptures have been reported; when combined with the present series, a total of sixty patients with 117 tendon ruptures became available for review. No characteristic pattern of disease process is to be discerned in this group since all were individuals with rheumatoid arthritis of moderate or greater severity developing tendon ruptures in the hand or about the wrist with trivial or no precipitating trauma. Approximately 50 per cent of the patients did not recall pain attendant with the rupture. Sensation, when present, was usually described as a sharp pain, snapping sensation or like an electric shock in the wrist. Occasionally there was an audible "pop." In some instances rupture was preceded by pain and swelling of the wrist and dorsum of the hand characteristic of a tenosynovitis.

Activity of the patient at time of tendon rupture, although a contributing factor in some cases, appears to be of no great significance and was quite variable. Rupture has been observed to occur while in the hospital either during sleep or when lifting bed linens. Many patients cannot recall specific activity or the exact time of tendon rupture. On the other hand, there may be gradual awareness of marked tendon weakness or sudden loss of ability to flex or extend one or more digits.

Age and duration of rheumatoid arthritis does not differ significantly between the sexes (Table II). The youngest patient was twenty-five and the oldest eighty-seven. Duration of arthritis ranged from two months to thirty years. Wrist involvement was of only slightly less duration than the total arthritic process. The frequency of tendon rupture in men appears to be greater when one considers that rheumatoid arthritis occurs three times more often in women than in men. Multiple tendon rupture occurred in fifteen of twenty-six men as compared to fourteen of thirty-four

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TABLE I. TENDON RUPTURE IN RHEUMATOID ARTHRITIS
(15 Cases)

Case	Sex	Age	Duration R.A. (Yrs.)	A.R.A.[22] Stage	A.R.A.[22] Class	Rheumatoid Factor	Rheumatoid Nodules	Steroid† Therapy	Involved Hand	Tendon Ruptured	Cervical Subluxation
1*	F	36	1	I	II	—	Yes	No	R L	Ext. pollicis longus Flex. digitorum profundus II	—
2	F	55	1	I	II	Positive	No	No	L L	Flex. digitorum sublimus V Flex. digitorum profundus V	No
3	F	36	21	III	II	Positive	No	Yes	R L	Ext. digitorum communis IV, V Ext. digitorum communis V	—
4	M	61	6	III	II	Positive	No	Yes	R L	Ext. digitorum communis III, IV, V Ext. digitorum communis III, IV, V	—
5	F	50	8	III	II	—	No	No	R	Ext. pollicis longus	—
6**	M	54	11	III	IV	Positive	Yes	Yes	L	Ext. digitorum communis IV, V	C_1-C_2
7	F	60	27	IV	III	Positive	No	No	R	Ext. pollicis longus	C_1-C_2
8	F	43	8	III	III	Positive	Yes	Yes	R	Ext. pollicis longus	C_1-C_2
9	F	45	22	III	III	Negative	No	Yes	R	Ext. digitorum communis III, IV, V	C_1-C_2
10	M	57	20	III	III	Negative	No	Yes	R R	Flex. pollicis longus Ext. digitorum communis IV, V	C_1-C_2
11	M	69	15	IV	IV	—	Yes	Yes	R	Ext. digitorum communis III, IV, V	C_1-C_2, C_5-C_6
12	F	44	17	III	II	Positive	Yes	Yes	R	Ext. digitorum communis IV, V	C_1-C_2, C_6-C_7
13	F	42	2	III	II	Negative	Yes	Yes	L	Ext. pollicis brevis	C_1-C_2, C_5-C_6
14	M	56	12	IV	III	Positive	No	Yes	R L	Ext. digitorum communis V Ext. digitorum communis IV, V	C_1-C_2, C_2-C_3, C_4-C_5
15*†	M	54	16	IV	IV	Positive	Yes	Yes	R R L	Ext. digitorum communis IV, V Long head biceps Ext. digitorum communis IV, V	C_1-C_2, C_4-C_5, C_5-C_6, C_6-C_7

†Continuous administration for one or more years
*Subject of previous Case Report 13
**Subject of previous Case Report 20
*†Subject of previous Case Reports 13, 14, and 20

women. The greater frequency in men may possibly be attributed to more vigorous use of hands and wrists.

Handedness of patients does not assume the importance expected. The right hand was affected in thirty patients, left hand in twenty, and ten patients had bilateral involvement. A total of seventy-four ruptures occurred in the right hand and forty-three in the left hand.

TABLE II. COMPARISON OF SEX IN CASES OF TENDON RUPTURE

	Female	Male
Number of patients	34	26
Average patient age (years)	49	51
Duration of arthritis (years)	10.5	10.5
Total number of ruptures	59	58
Number of multiple ruptures	14	15

Clinical evidence of active arthritis was present in all patients. Erythrocyte sedimentation rates were elevated in all instances reported. The serologic test for the rheumatoid factor was positive in 72 per cent of the patients tested. Rheumatoid nodules were noted in approximately 50 per cent of the cases. Wrist involvement was a consistent feature in all patients but the roentgenographic picture varies from mild changes of juxta-articular osteoporosis to a very severe destructive process of bone.

TABLE III. TENDONS RUPTURED IN 60 CASES OF RHEUMATOID ARTHRITIS

Tendon	Number Ruptures	Per Cent
Extensor digitorum communis	67	57.3
Extensor pollicis longus	26	22.2
Extensor digiti quinti proprius	9	7.7
Flexor digitorum profundus	5	4.3
Flexor digitorum sublimus	3	2.6
Flexor pollicis longus	3	2.6
Extensor pollicis brevis	2	1.7
Abductor pollicis	1	.8
Long head of biceps	1	.8
Total	117	100.0

The extensor tendons were the most commonly involved, accounting for 89 per cent of all tendons ruptured (Table III). More than half of all ruptures occurred in the extensor digitorum communis tendon. Multiple digit involvement of this tendon was quite common and not infrequently associated with rupture of the extensor digit quinti proprius tendon. Rupture of the flexor digitorum sublimus tendon may remain

unnoticed in the presence of intact pro fundus function and may be more frequent than indicated.

Earlier reports attributed tendon rupture to rheumatoid granulomas,[2] tenosynovitis[6] or a combination of these factors with erosion of tendon by roughened bone.[7] Vaughn-Jackson has stressed the role of mechanical attrition as the etiologic factor in both flexor and extensor tendon rupture;[5,12] an abrading spicule of bone was found to have severed the tendon in each case; one may question the reported macroscopic and microscopic normality of the involved tendons. A detailed pathologic description by Ehrlich and coworkers of extensor digitorum communis tendon rupture substantiates the hypothesis that erosion by bone spicules may be a major factor.[9] Chronic inflammatory changes were present in all tendons involved and one case showed vascular and tendon necrosis of the rheumatoid type.

Surgical repair of tendon ruptures has been made in nine patients in The University of Michigan experience. In only one patient (Case 13) was there neither significant gross nor histologic abnormality of tendon; unmistakable chronic inflammatory changes were demonstrable in the remaining eight individuals. These included necrosis, degeneration and cystic changes in tendon with fraying and fragmentation of the tissue. Marked invasion of tendon substance by an inflammatory reaction of lymphocytes, histiocytes and plasma cells was a consistent finding. In some areas, lymphofollicular development was quite prominent. Hemosiderin deposits and some degree of free hemorrhage were usually found. A few small areas of fibrinoid necrosis were noted. One case clearly demonstrated the presence of rheumatoid nodules (Case 1)[13] while there was a strong suggestion of this formation in two other specimens (Cases 3 and 9). These changes, although nonspecific, are compatible with rheumatoid tenosynovitis.

Observations by others[15-16] suggests that in patients with rheumatoid arthritis the incidence of tendinitis or tenosynovitis varies from 42 to 48 per cent. If tendon lesions were the prime factor responsible for rupture of the tendon, this phenomenon might be expected with much greater frequency. Furthermore, rheumatoid tendon involvement occurs primarily in the flexors of the fingers which would not contribute to the predominance of extensor tendon ruptures. Were mechanical attrition the sole etiologic process, a higher incidence of tendon ruptures would be expected. By roentgenograms large numbers of patients with rheumatoid arthritis but without tendon ruptures can be demonstrated to possess even more extensive bone changes at the wrists. Conceivably this would permit operation of the same mechanical factors and rupture does not occur. It appears reasonable to conclude that in most cases a combination of bony abrasion and chronic inflammatory reaction of tendon is responsible for eventual rupture of the tendon. In many instances the inflammatory process has the characteristics of a rheumatoid tenosynovitis.

Spontaneous atlanto-axial subluxation has been considered a rare complication of rheumatoid arthritis.[17,19] A recent study[20] emphasizes the actual prevalence of this condition and more clearly defines the pathologic processes present. Erosive changes of the odontoid due to ingrowth of proliferating pannus were observed. Chronic inflammation and fibrinoid necrosis of ligaments, associated with chronic synovitis, was noted in the areas adjacent to the odontoid.

Eleven patients with spontaneous tendon rupture in the University of Michigan series were examined radiographically with flexion and extension views of the cervical spine. Two of these patients were known to have atlanto-axial subluxation; the remaining eight patients were selected at random. Ten patients demonstrated some degree of atlanto-axial subluxation* and in five subluxations of other cervical vertebrae were noted. In these individuals with cervical spine subluxation the diagnosis of rheumatoid arthritis was definite or classical; and progression was either Stage III or IV.[22] Neck symptoms, although present at some time during their disease course, were not necessarily a prominent complaint at the time of this study.

Spontaneous atlanto-axial subluxation may result from incompetence of the transverse ligament, responsible for normal atlanto-axial alignment, or from diminution of odontoid mass by erosive processes. It may be assumed that the transverse ligament is predisposed by anatomic relationships to the same factors operable in production of tendon ruptures at the wrist. Atlanto-axial subluxation, when due to rupture of the transverse ligament, could result from pathologic processes similar to those associated with spontaneous tendon rupture. The association of these two complications in an individual with rheumatoid arthritis is very likely a reflection of the severity and widespread distribution of this inflammatory disease.

In the light of these findings, careful examination of the cervical spine, including radiographs, is warranted in selected patients with rheumatoid arthritis who develop spontaneous tendon rupture. The potential danger of cervical spine subluxation is apparent.

*"Subluxation" is defined in terms of known normal measurement as established by Jackson.[21]

Management of this condition depends on the severity of associated symptoms and the degree of subluxation. In some instances fusion of the cervical spine may be required; most patients, however, require only a properly fitted and adjusted brace to insure proper support and alignment of the neck. Surgical repair of tendon ruptures is, of course, indicated to obtain functional improvement and to protect the digits from trauma. Repair is usually accomplished by tendon transplant or free tendon graft with gratifyingly successful results.

Discussion

Spontaneous tendon rupture and cervical vertebral subluxation, once considered rare complications of rheumatoid arthritis, are now recognized with greater frequency. One may question whether this reflects a real or an apparent increase in prevalance. In the past year, twelve cases of spontaneous tendon rupture have been observed at The University of Michigan Medical Center; only three additional instances were recorded in over 6000 patients with rheumatoid arthritis seen during the previous twenty-year period. More recently, in the same center, special interest has developed in the likelihood of involvement of the neck in the individual with this disease.

One can only speculate as to factors possibly related to the development of these complications. Without a doubt the use of effective measures of physical therapy in patients with active rheumatoid arthritis results in maintenance of greater range of motion in diseased joints. Furthermore, adrenocortical steroids, by suppressing joint pain, very likely often permit increased functional range of joint motion. It is not unlikely that these two treatment modalities, in the susceptible individual, permit a longer period of erosive action on tendons which are especially vulnerable to the underlying relentless disease process; in some instances, these go on to rupture.

Increased awareness by the physician of these bizarre complications in rheumatoid arthritis undoubtedly will lead to increased frequency of diagnosis. In a deformed hand with pre-existing limited functional capacity it is very easy to overlook tendon rupture or its development. Moreover, patients frequently accept this accident as part of the arthritis process, not consulting the physician unless it becomes particularly troublesome. Minimal cervical vertebral subluxations may not be shown by conventional radiograms with usual positioning of the patient; laminagrams or comparative radiographs with the neck in flexion and extension will, however, clearly demonstrate this abnormality. That the spine and neck, in the patient with classical or definite rheumatoid arthritis of peripheral joints, may be involved is not commonly appreciated by most physicians. Moreover, neck symptoms may not be prominent and are commonly not mentioned by the patient or are attributed by the physician to muscular rheumatism.

Summary

Fifteen cases of spontaneous tendon rupture in rheumatoid arthritis are presented and sixty cases are reviewed. Previously unrecognized coexistence of cervical subluxation can be demonstrated in many patients. The pathology and possible contributing factors are discussed. Increased awareness by physicians will provide more frequent diagnosis of these complications.

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Blood from the Dead

The 41-year-old woman in Pontiac General Hospital was anemic and needed blood transfusions to build her up for an operation. From the refrigerator, doctors took a pint of matching (Group A, Rh-positive) blood that had been stored for 19 days and transfused it into one of her veins. By the next day her blood counts were somewhat better, but to be on the safe side, the doctors gave her the concentrated cells from another pint of blood from the same donor.

What made this otherwise routine case remarkable was that the donor was a dead boy of twelve, who had drowned in a nearby lake. After all attempts to revive him had failed, Pathologists Jack Kevorkian and Glenn W. Bylsma did an autopsy and withdrew two pints from a jugular vein. This was 2½ to 3 hours after death. To make sure that no germs had got into the blood (which would make it unsafe for transfusion), samples were incubated for two weeks. The woman patient, who had no unfavorable reactions to the transfusions of cadaver blood, is now well and at home.

Pathological Prejudice.—This was the fourth time that Drs. Kevorkian and Bylsma had supplied cadaver blood for transfusion. In three previous cases the attending physicians tried it cautiously, and only on incurable patients. Yet using cadaver blood is not a new practice. At Moscow's Sklifosovsky Institute, almost 30 tons of it have been given in 30,000 transfusions since the method was first tried there in 1930. U. S. doctors have shied away from it because of prejudice against contact with anything taken from a corpse. The Pontiac pathologists hoped that this prejudice was weakening with wider acceptance of corneal grafting and the transplanting of bone and arteries from accident victims.

Use of cadaver blood offers several advantages. A living donor may lie about his health, especially about such a vital question as whether he has had hepatitis. Moreover, he cannot comfortably give more than a pint every two or three months. The corpse cannot lie, and the pathologists doing an autopsy can check every vital organ for disease—including the liver for evidence of hepatitis. They select as donors only the corpses of presumably healthy individuals who die suddenly, as in traffic accidents or from heart attacks. A cadaver yields far more blood than a walking donor: The Pontiac investigators have drawn as many as three pints from a grown man; the Russians say they get as many as eight pints.

Safety Rules.—Drs. Kevorkian and Bylsma thought that they were applying the Russian method for the first time in the U.S. Then they learned, from a recent *Bulletin* of the American Association of Blood Banks, that as long ago as 1935 Surgeon Leonard L. Charpier had used a similar technique in a Chicago suburb. Dr. Charpier kept the work secret and died without writing up his records. But he was responsible for about 35 cadaver-blood transfusions in two years. Then the modern system of blood banking, which permits blood to be stored for three weeks without deterioration, was developed.

A few strict rules must be followed in using cadaver blood. It must be drawn within six hours after death from a subject with no known infectious disease, and a complete autopsy must be done. When these conditions are met, say the Pontiac doctors in *Clinical Pathology*, "we know it can do no harm and that it offers tremendous potential good."—*Time*, May 26, 1961.

Common Problems of the Aged in Physical Medicine and Rehabilitation In a County Hospital

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AN OVER-ALL dynamic program of physical medicine and rehabilitation in this institution has been described in a previous publication.[1] The bed capacity consists of 3500 psychiatric patients, about 500 patients in the General Hospital Division for acutely ill, about 800 chronically ill patients in the Infirmary Division, and about 1800 ambulatory indigent persons in the Infirmary.

It is the purpose of this article to describe some of the following commonly encountered problems of aged patients that are related to physical medicine and some of the everyday nursing problems in the general hospital and in the institution's infirmary for chronic diseases: (1) management of the older amputee, (2) prevention and treatment of flexion contracture deformities in neuromusculoskeletal diseases, (3) care and prevention of decubital ulcers, and (4) training for bowel control.

Management of the Older Amputee

We have a large number of elderly amputees, most of whom have amputation of a lower extremity as a result of occlusive peripheral vascular disease. In evaluating the amputee for prosthesis, we are guided by physiologic and not chronologic age. An older amputee, in good physical condition, presents no specific problem in training nor use of the artificial limb—whether his amputation is below or above the knee—providing he cooperates and follows instructions. Older debilitated patients with bilateral knee amputations usually do not desire prostheses as long as they are furnished with wheel chairs and instructions for their proper care. However, amputees who can hardly walk with crutches, have poor coordination and balance, insufficient muscular strength and poor circulation in the other leg, present a real problem. These patients generally are not satisfied to be told that they are not candidates for a prosthesis, and will often insist that they should be supplied with an artificial limb or a prosthetic device.

In order to satisfy the desire of these patients to use an artificial limb, we use a provisional or temporary prosthesis for amputations below or above the knee.[2] Success in use of an artificial limb in such cases is doubtful because of physical and medical reasons. The provisional prosthesis is made from an old prosthesis in satisfactory condition in which the wooden socket is substituted by one made from plaster of paris. It is made and aligned by a trained orthotist and its cost is about 10 per cent of a regular prosthesis. If routine training with this type of prosthesis is successful, a regular prosthesis is ordered; if not, the patient is usually satisfied with a wheel chair and will complain no longer.

Several factors must be considered if rehabilitation of the elderly amputee is to be successful. First of all, the patient should be psychologically prepared for loss of one of his extremities. Plans for possible ambulation with an artificial limb should be discussed before amputation takes place. Usually he will be visited by an amputee who has had training with a prosthesis in our department to help him make a decision regarding amputation. The patient's condition should also be carefully evaluated by the surgeon before amputation takes place; if possible, the knee should be saved since it quite often means the difference between walking or confinement to a wheel chair. We have more success in the rehabilitation of the

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older patient with amputations below knee than with amputations above the knee. The length of the stump is important in proper fitting. In amputations below the knee, the length of the tibia should be from 5 to 6 inches with the fibula 1 inch shorter; in amputations above the knee, the stump should be 3 inches above the knee. The closer the amputations approximate these dimensions, the better will be the control of the stump. Routine postoperative care of the stump should follow, placing emphasis on shaping of the stump with a rubber reinforced Ace bandage, maintenance of the range of motion and strength in the remaining lower extremity and the stump, strengthening the abdominal muscles if they are weak, and early ambulation with crutches.



Fig. 1. Therapist instructing ward personnel in simple range-of-motion exercises for bedridden patient.

Good hygiene of the stump is to be maintained during the training period and after the patient is discharged to his home. Frequent ulcerations of the stump and folliculitis at the suture line respond very well to whirlpool baths.

In amputation stumps below the knee, indurated scars that ulcerate frequently and heal slowly with some degree of edema clear up satisfactorily if the stump is allowed to bear weight partially during walking on a platform inserted in the socket and covered with sponge rubber. Weightbearing should not exceed 10 per cent of the patient's body weight. This intermittent pressure on the end of the stump promotes mechanical lymphatic drainage from the stump and improves the general condition of the stump.

Some patients with amputation below the knee develop painful bursitis over the head of the fibula from an ill-fitting prosthesis or for some other reason. This is difficult to manage conservatively; the condition usually subsides with physical therapy, but recurrence may take place when the patient starts using prosthesis even with adjustment of the socket. The only successful treatment is surgical excision of the remaining portion of the fibula and adjustment of the socket with a new liner.

We have employed this method recently in two patients with good success. One of these patients was unable to walk without discomfort and went from one hospital to another for three years because he was unable to use the prostheses furnished—despite adjustments of the socket or prostheses. Utilization of the surgical approach described above contributed to his full physical rehabilitation.

Even elderly patients with a colostomy can be successfully rehabilitated with a suction socket prosthesis in amputations above the knee.

Illustrative Case

Case 1.—A sixty-three-year-old well-built man, a laborer, had diabetes mellitus, had a colostomy and resection of the bowel performed because of carcinoma of the rectum one and one-half years prior to admission to our hospital. Two weeks later he had a mid-thigh amputation of the left leg for arteriosclerotic occlusion of left popliteal artery with gangrene of the foot. After he was given a training leg for about two weeks, prolapse of the colostomy was noted. After the colostomy was surgically corrected, the patient completed his training; he has now successfully used the suction socket prosthesis without any difficulty for the last six months.

Comment.—It should be emphasized again that patients who are not candidates for a prosthesis should always be furnished with a special type of amputee-wheel chair. They should be trained in its use for full functional independence so that they can actively participate in the social life of their environment.

Prevention and Treatment of Flexion Contracture Deformities in Neuromusculoskeletal Diseases

About half of the patients treated in this department are patients with neuromuscular disease. The majority of these patients have cerebrovascular disease. The detailed description of the programs of physical therapy for such patients is beyond the scope of this paper. In general, it should be emphasized that the rehabilitation project is of long duration. Definitive diagnosis of location and severity of the brain lesions should be made before physical treatment is prescribed and the medical problem adequately managed. Often it seems hopeless to begin treatment in a patient who is markedly confused, has poor control of bladder and bowel, poor balance, or requires the aid of two or three persons in order to stand up at the parallel bars. Although these attempts may be discouraging, they should not be stopped since functional recovery depends so much on the intensity of the daily treatment. These problems are usually short-lasting and often clear up with gradual increase in physical activities. Even though progress is slow and sometimes disappointing to the therapist, treatment should be continued for a while since the patient often regains much of his physical functional independence and should be stopped only when he definitely reaches a plateau in his physical activities. Long or short double upright braces, usually short with spring ankle joints, will facilitate the final stage of ambulation.

In our department, we have had good over-all results from the long-term treatment of patients with cerebrovascular disease. Some patients have returned to their former employment. Most of these patients return to their families or convalescent homes, with instructions to continue the previously prescribed home program of exercises. The remainder are transferred to chronic disease hospitals for custodial care, usually because the patient has no relatives who will accept him in their homes, or the involvement and disability are too great for a relative to cope with the nursing problem.

The transfer of such a patient with neuromusculoskeletal involvement to a hospital for chronic diseases or a convalescent home without instructions for a program of daily simple exercise is often disastrous. Quite often we receive patients from other hospitals, nursing homes or their own homes who have spent



Fig. 2. Patient with provisional prosthesis for below-knee amputation.

months lying in bed or sitting at the bedside. These patients usually develop serious deformities of the involved extremities. The most troublesome of these are pari-arthritis, subluxation, adduction contractures and internal rotation of the shoulder; elbow, wrist and finger flexion contractures; hip and knee flexion contractures with external rotation; inversion and plantar flexion of the foot. As a result of complete physical inactivity with continual dependence on others, this type of patient gradually develops severe functional "overlay," becomes increasingly difficult to handle, and usually demands more and more service. A fixed mental pattern develops and there may be little that an active physical therapy program can do to restore the normal range of motion in the involved extremities or make the patient ambulatory.

In order to prevent these complications, the pro-

gram of simple exercises which was initiated in the Department of Physical Medicine and Rehabilitation is continued in the wards of the hospital or infirmary. The nursing staff and attendants are instructed by the physiatrist and the physical therapist in exercises. Subsequently they should see that the patient carries out these exercises two or three times daily whenever the nurse or the attendants are at the patient's bedside, washing him or attending to his other daily needs. Proper positioning of the patient in bed is also stressed. To maintain the anatomic position of the extremities and prevent flexion contracture deformities, pillows and sand bags are used.

A flail upper extremity should always be supported by a simple or special type of sling whenever the patient is sitting or walking. The lower extremity should be elevated when sitting on another chair or bed. Occasionally when the patient cooperates poorly, posterior splints with turnbuckle are used for stretching of the contracted knee joints. Patients are always encouraged to continue ambulation—even if in a limited fashion—and other daily personal activities like feeding, combing the hair, and brushing the teeth as prescribed for quadriplegic or paraplegic patients.

Excellent cooperation in this program has been given by ward personnel who feel that the addition of this type of assistance makes their work more interesting and their role more important in the general care of the patient. Wards with these active programs are visited frequently by the physiatrist and therapist—at which time, other related problems are discussed with the patients to indicate a continual interest in their welfare.

Prevention and Care of Decubital Ulcers

One of the most difficult everyday problems related to chronically ill patients is the prevention and care of ischemic or decubital ulcers. The problems in the conservative or surgical treatment of decubital ulcers has been well described.[3] The detrimental and debilitating effects of decubital ulcers on the general physical condition (because of loss of plasma protein resulting in a negative nitrogen balance and the importance of its correction by a high protein diet on the healing process of decubiti) are well presented by Mulholland.[4] A good percentage of our patients in the chronic disease section of our hospital are limited in their functional activities because of neuromusculoskeletal involvement. They are likely to spend most of the time in one position while lying in bed or sitting at the bedside and may not move because of physical inability or because of loss of sensation to painful stimuli as a result of prolonged sitting and lying. Because of these factors, prevention of ischemic ulcers is an everyday problem.

The most frequent areas of involvement are the weight-bearing bony prominences which are protected only by skin and a thin layer of subcutaneous tissue, such as the sacrum, trochanters, ischial tuberosities and heels; and, in more severely involved patients, the scapulae, knees and feet and sometimes the entire hip regions.

Regardless of the many hypotheses regarding the etiology of decubital ulcers, ischemic neurotrophic and metabolic factors are of utmost importance. Time and pressure are the most significant factors as demonstrated by Kosiak.[5] Ischemic ulcers were produced both by high pressures applied for a short duration and by low pressures applied for a long duration.

Since living tissue is so vulnerable to ischemia, frequent relief from pressure in the critical weight-bearing areas is of utmost importance. There is no substitute for a Stryker and Foster bed in the care of paraplegic or quadriplegic patients, with meticulous observance of turning schedules and careful handling of the patient during routine daily nursing activities. When decubiti heal, some patients may acquire use of a hospital bed with foam rubber mattresses, but the patient's understanding of the necessity of frequent change in his position plays an important part in the prevention of ischemic ulcers. Also, wheel chairs should be used with cushions having 2 or 3 inches of foam rubber covered with plastic material.

Many well known methods have been described for the conservative and surgical care of decubiti.[6] Most hospitals with a large number of chronically ill patients have their own conservative methods for dealing with decubiti. These methods include different chemotherapeutic agents, such as Panafil (papin urea chlorophyllin),[7] special dressings, skeletal suspensions,[8] and special air mattresses. In our conservative approach, we use dry plasma and Peruvian balsam, as described by Rusk[9] and we have obtained results comparable with his. The advantage of this method is that dressings are changed only every fourth day and the patient, if able, continues his physical activities. The results are as good or better than any other method we have previously employed. Special printed instructions are given to the ward nursing personnel. The general medical status of the patient is evaluated before this treatment is started and a high protein diet with supplement of vitamins, is usually ordered. After one or two applications of dry plasma and Peruvian balsam, fresh granulation

appears, the necrotic tissue and the infection gradually disappears leaving a good bed for skin graft, or complete healing may take place. If the final stages of healing of the decubital ulcer progresses very slowly, we apply a tissue stimulant, as in the case of small superficial ulcers.*

Patients with high spinal cord injuries and flaccid paralysis of the extremities should have the decubiti debrided and cleaned with dry plasma, and the sacral and ischial tuberosities removed, after which full-thickness type of skin grafts should be applied.

Briefly then, it can be said *prevention is the best method of care of decubital ulcers;* if they exist, combined conservative and surgical treatment gives the best results.

Bowel Control

Bowel control of the patient is governed mainly by central and autonomous nervous system, the act of defecation being voluntary or involuntary. If the voluntary control of the central nervous system is removed, bowel movement will depend completely on autonomous control of the sympathetic and parasympathetic systems.

Conditions affecting cortical function, like severe brain or cord damage from trauma and progressive involvement as in senility, will cause fecal incontinence.

Bulbar level of bowel control also plays an important part in bowel function. A defecation center situated in the floor of the fourth ventricle can cause complete inhibition or sudden evacuation of the bowel, depending on sympathetic or parasympathetic stimulus such as occurs in anger or stress.

The spinal center of defecation being situated in the second, third and fourth sacral segments, assumes control of the bowel when cortical control is removed. This is most often encountered in patients with spinal cord injuries in whom the act becomes autonomous. In involvement of the sacral segments of the cord, the rectum and bladder are still capable of controlling the evacuation through the mechanism of its intrinsic nervous system.

Mostly, the programs of bowel training concern patients with spinal cord injuries but such programs have also been successful in senile ambulatory patients. Adequate bowel control is essential for the patient with spinal cord injuries, not only for his feeling of well-being but also because of the important role it plays in prevention of decubital ulcers and in permitting him to participate in social activities.

Attempts are usually made during bowel training to return the patient to his pre-morbid habits with bowel emptying every day or every other day. Twelve hours prior to his expected bowel movement, the patient is given 2 or 3 ounces of prune juice. The next day, about one-half hour before the desired bowel movement (usually after a meal), a glycerin suppository is inserted into the anus past the internal sphincter with the patient lying in recumbent position for twenty minutes. The patient then attempts to have a bowel movement while he is in a squatting position, utilizing a low bedside commode or a regular toilet. If he is not successful, another suppository should be inserted and if this fails, an enema should be given and the program started again the next day. During the waiting period, which could be from twenty minutes to one hour, the patient should be relaxed, or permitted to smoke a cigarette. Sometimes irritation of the rectum by a gloved finger is helpful.

The program, as described above, should be carried out for two weeks. Routine bowel habits are usually established during this period of time. Enemas should be avoided unless all other methods for bowel training have failed. Good daily fluid intake and cooperation of the patient is essential for successful bowel training. Properly instituted programs of bowel training contribute to better general health of the patient and decrease the nursing work as well as the expense of laundering of extra linen. Problems of bladder control are managed by our Department of Urology staff.

Conclusion

The most common problems of physical medicine and rehabilitation of the aged in Wayne County General Hospital are presented and proper management described. The family relationship and the home play an important role in the final stages of rehabilitation of older patients after they have suffered the disaster of a cerebrovascular accident lesion, an amputation of an extremity, or have met other serious physical disability. Patients having a good home life and the possibility of returning home, will cooperate more fully, work harder in their daily program of physical activities, and will be more successful in the final stages of physical rehabilitation than patients who have no visitors and no prospect of returning home. These patients often utilize their disability as an excuse to remain in the hospital, thus placing an extra financial burden on the community.

Early initiation of a program of physical rehabilita-

*Tissue stimulant ointment containing Win 13,441 (hydroxymethylandrostadieneone) 1% from Winthrop Laboratories.

tion following the onset of disability is of utmost importance in the management of the elderly patient. The Department of Physical Medicine and Rehabilitation in this hospital has participated in the program of rehabilitation of many elderly patients who have required long-term rehabilitation and who, because of medical and financial reasons, could not be kept in private hospitals. Patients with some potential for rehabilitation should be screened by a physiatrist before being sent to a convalescent or nursing home for custodial care.

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Central Pontine Myelinolysis

A demyelinating disease limited to the central portion of the pons was first described in 1959 by Adams et al. The absence of this condition from the neuropathologic literature and from their own earlier material led these authors to suggest that this was a new disease, which they associated with alcoholism and/or malnutrition. Three more recent reports have contributed four additional cases of this disease, making a total of eight that have now been described.

The purposes of this report are to document eight new instances of this disease and to analyze its relationship to other lesions, especially those of alcoholism and malnutrition.

Demyelinating diseases are defined as those in which there is primary or predominant loss of myelin sheaths, with relative preservation of axis cylinders. The pathologic process in central pontine myelinolysis conforms to this definition. The lesion is limited to the region of the central portion of the base of the pons, extending symmetrically to either side of the median raphé. It can be recognized grossly in the fixed specimen by its characteristic brown or gray granular appearance, and its sharp demarcation from the surrounding normal white matter. In one of our patients who was jaundiced at the time of autopsy, the pontine lesion was also jaundiced, an interesting observation with regard to the blood-brain barrier. The destruction of myelin, while characterized by its eventual breakdown to neutral fat and its removal by macrophages, passes through a stage in which the material is PAS-positive. The axis cylinders appeared to have been unaffected except in one instance by the process. Within the lesions there were few or no identifiable oligodendrocytes, although these cells were present unaltered in the adjacent tissues. The blood vessels within the lesions were sometimes dilated but were otherwise unchanged, in contrast to the vascular changes seen in Wernicke's disease. Occasionally, reactive astrocytes in small numbers were found at the margins of the affected areas.

The relatively large number of patients with central pontine myelinolysis in this series may be related to the large number of autopsies from which this material was obtained and to the nature of the autopsy material. In each of the hospitals the autopsy population contains many individuals with both gross and microscopic evidences of malnutrition and with clinical as well as autopsy evidences of diseases related to alcoholism. The apparent newness of this condition and its association with malnutrition, alcoholism and liver disease suggests two possibilities: (1) There may be a new toxic factor in alcoholic beverages that is not detoxified by the diseased liver, or (2) a new selective nutritional deficiency is permitted to develop in patients whose diets are artificially supplemented by the currently available vitamin preparations. The evaluation of these speculations, however, must await experimental production of these lesions.—James W. Landers, M.D., Jacob L. Chason, M.D., and J. E. Gonzalez, M.D., Department of Pathology, Wayne State University College of Medicine, Detroit Physiological Society, May 18, 1961.

Acute Renal Failure with Oliguria or Anuria

A *Commentary*

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FROM THE pediatricians' viewpoint, glomerulonephritis, either acute or chronic, ranks first numerically as the cause of acute renal insufficiency with oliguria or anuria in childhood. However, the younger the subject, the greater the possibility that other causes may be implicated, which require consideration in the differential diagnosis. These causes include especially the vascular lesions, such as renal vein thrombosis, or renal cortical necrosis; the acute tubular necrosis syndromes secondary to poisons or acute anoxia or, intravascular hemolytic reactions, and rarely, to renal failure associated with congenitally abnormal kidneys, either alone or accompanied by secondary genitourinary tract infection.

At the time of admission of pediatric subjects with acute renal failure, generally the complaints given by the parents do not focus upon the urinary tract, but instead center upon such non-specific complaints of vomiting, abdominal pain, lethargy, rapid breathing, dehydration, diarrhea, or pallor. Frequently, it is only after rehydration has been instituted that the absent or scanty urine output is noted, and by this time, edema has usually become evident.

Although renal failure is associated with marked elevation of the blood urea nitrogen or non-protein nitrogen levels, infants and young children may have increases of blood urea nitrogen to 150 mg. per cent or even higher as a consequence of dehydration alone. It is thus necessary to rehydrate in a reasonable manner before concluding that anuria is renal in origin. As a rule, after four to six hours of intravenous fluids, even severely dehydrated subjects will begin voiding. If it is recognized that despite fluid therapy, the patient is not urinating then serious over-hydration may be prevented.

However, when acute renal failure is detected in an infant or child, a careful reappraisal of the history to identify possible nephrotoxins or hemolysins is required, for certain toxins, particularly the heavy metals may be inactivated by appropriate therapy, and hemolytic anemias may be identified by knowledge of toxins ingested or by appropriate hematologic studies.

Once the diagnosis of acute renal failure is made, efforts should be directed toward supporting the patient in anticipation of a return of renal function. As previously noted, death in acute renal failure may be most frequently attributed to over-hydration, hyperkalemia or secondary infection.

The need for water is markedly reduced in the anuric subject, and in the absence of significant gastrointestinal losses, is limited to skin and lungs only. Ten cc./pound/day for an infant or child is generally adequate for these needs. It should be re-emphasized that tissue catabolism continues and adds water to the body pool. Thus, the well-managed anuric child should neither maintain a constant weight nor show a gain but instead should demonstrate a daily weight loss. For example, a five-year-old should lose at a rate of $\frac{1}{4}$ to $\frac{1}{3}$ pounds of weight per day. Only by careful daily weights can fluid administration, either orally or parenterally, be planned.

In regard to electrolyte needs, anuria is perhaps the only disease state in pediatrics during which maintenance needs for electrolytes are nil. Despite a recent report[1] advocating the prophylactic administration of sodium salts, we have not subscribed to such a program and have instead reserved alkali administration for patients with sufficient acidosis to result in moderate or severe hyperpnea. In such subjects, alkali in the form of $NaHCO_3$ has been given to the point of stopping the hyperpnea.

On the other hand, excessive accumulation of potassium is a true hazard. In anuria, the serum potassium rises at a rate of approximately $\frac{1}{2}$ mEq./day.

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At approximately a serum concentration of 7 mEq./liter, we have begun therapy to lower the body's circulating potassium. The sodium loaded exchange resins can be extremely effective in infants and children when administered rectally. We have utilized these by suspending 20 gm. or 1 tablespoon in 100 cc. of 10 per cent glucose. Dependent upon the size of the subject, 20 to 100 cc. are given as a retention enema. With very high potassium levels, these are repeated at two to four-hour intervals, and in lesser degrees of hyperkalemia, two to three times a day. A decrease of serum potassium concentration from 9 to 4 mEq./L. has been accomplished in a 24 hour period in one infant by this method. For an immediate but temporary lowering of serum potassium concentrations, 3 per cent NaCl or 3 per cent $NaHCO_3$ is effective when given intravenously, but after one to two hours, reshift of potassium occurs and thus this is only an emergency type of procedure for use during impending cardiac arrest.

The need for calories continues in the anuric child. We have limited the source of calories to carbohydrates, and in particular to those carbohydrate foods which are low in potassium such as rock candy, sugar cubes, marshmallows, canned peaches, and canned cranberry sauce. Generally an intake of approximately 2 gm. of carbohydrate/pound/day will decrease tissue protein utilization and prevent ketosis. The safety of the intravenous fat preparations has been suggested by a recent article[1] but the earlier reports of hemolytic anemia and thrombocytopenia associated with their use prompts a note of caution. We have not utilized these available preparations as yet, but further reports may document their margin of safety.

Unfortunately, certain pediatric patients do not have a rapid return of renal function and the problem of the need for dialysis arises. First, the physician must decide upon the indications for dialysis. In the limited experiences thus far available, it would appear that the pediatric subject displays a similar pattern as the adult, but with certain exceptions. As a rule, children tolerate higher degrees of waste accumulation as reflected by blood urea nitrogen levels, before symptoms of vomiting, drowsiness, or coma supervene. The blood urea nitrogen then, may be a guide to the degree of waste accumulation, but alone need not be the determinant point for dialysis. By use of the cation exchange resins, hyperkalemia can be managed without dialysis, and rarely does hyperkalemia alone justify dialysis. To summarize, the child with anuria whose mental state is deteriorating, as manifest by onset of vomiting, lethargy, disorientation or, rarely, hyperactivity, is a candidate for dialysis.

The previous case reports document the successful use of the artificial kidney in infancy and supplements earlier reports of its use in older children. However, what are the other means available for dialysis which might be closer at hand than this technique which requires a high degree of skill and experience? At the present time, the major possible procedures are either exchange transfusion or peritoneal dialysis.

The efficiency of exchange transfusions in removing sufficient quantity of bilirubin from newborn infants to prevent brain damage is well-known. Recently, the technique has been employed in the therapy of accidental poisonings in childhood. It is difficult to be certain of absolute comparisons, but in one study the data showed[2] that during the two-hour procedure, salicylate was removed at twice the renal rate of excretion. However, twice the blood volume of the subject was required in the procedure. Previous studies[3] reported that dialysis by the artificial kidney removed salicylate at rates eight to ten times renal excretion values. It would appear that exchange transfusions may be helpful in acute poisoning to reduce blood concentration, but that the risks of hemolysis, high potassium content of bank blood and the opportunity for infection outweigh the slight reduction in total body wastes to be effected by the technique in subjects with anuria.

The second alternative method, peritoneal dialysis, was attempted in one of the subjects. In this technique, a plastic, multi-holed tube is inserted into the lower portion of the abdominal peritoneal cavity, and fluid infused and withdrawn at intervals. Previously, we had used this technique with excellent results in one infant, reducing the blood urea nitrogen from 140 mg per cent to 40 mg per cent over a twelve-hour period. However, in the present subject, the procedure was unsuccessful. The difficulty was due to inability to recover the infused fluid in this infant with resultant over-hydration. Whether to attribute this failure to an increased absorptive capacity of the infant's peritoneum or to errors in technique is not certain. Nevertheless, the procedure is not as consistently successful as has been reported for adult subjects. Perhaps, newer methods such as adding albumin to the infusing solution will improve the procedure in infants. Further exploration is needed in this field and potentially a useful technique for managing accidental poisoning as well as anuria may be developed.

Despite the superiority of the artificial kidney in dialysis, the hazards of the procedure must be considered for each patient. In the young child, as in the adult, transfusion reactions, intracranial hemorrhage or secondary infection may occur. In addition, the smaller the subject, the greater the problem of blood volume changes between the patient and the artificial kidney circuit. Such changes may operate in either direction. If flow from the subject is faster than the return, then cardiovascular insufficiency may occur. On the other hand, excess inflow to the patient from the apparatus may precipitate immediate cardiac overload. It can be calculated that the 500 cc. volume of the artificial kidney circuit is equal to 80 per cent of the one-year-old infant's total blood volume, to 50 per cent of the three-year-old child's blood volume, and to lesser amounts with increasing age. Thus, slight imbalance in either direction may precipitate a fatal crisis during dialysis. It has been demonstrated by the succusseful use of the procedure that these difficulties may be overcome, but the increased problems of small subjects requires considerable care.

In conclusion, the combination of common sense medical management plus careful intervention with dialysis provides for the young child with anuria, the opportunity for acute renal insufficiency to reverse. In more acute situations of ingestion of toxic materials, the artificial kidney may be a lifesaving device.

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Demonstration of Cerebral Arterial Thrombolysis by Fibrinolytic Agents

Experimental arterial thrombosis has been induced in the pial arteries of monkeys and cats by the intra carotid injection of powdered pumice particles 5-40 mu. in size. The particles damage the arteriolar endothelium and within thirty to ninety minutes progressive red (fibrin, erythrocytes plus platelets) and white (fibrin plus platelets) thrombi form. Photographs of the cerebral thrombi are made through specially designed windows screwed into the skull, and photographs are taken at regular intervals with a magnifying camera and flash assembly. Blood pressure is continuously recorded and samples of blood before and after treatment are analyzed for fibrinolytic activity. Bovine fibrinolysin activated with chloroform in doses of 50 Loomis units per kg. of body weight and human fibrinolysin activated with streptokinase (5000 Merck, Sharp and Dohme units per kg. of body weight) have been evaluated. Both fibrinolysin preparations produced clot lysis beginning within ten minutes of intravenous or intra-arterial injection. The human material activated by streptokinase was more satisfactory than the bovine material since clot lysis was more rapid and more consistent. After one hour, clot lysis was less active; after two hours, clot reformation was likely to occur unless an anticoagulant (heparin) was given concurrently. After one hour, a repeat injection resulted in complete lysis of the clot if any remained.

Preliminary studies in thirty-five human patients suffering from thrombosis of cerebral arteries and veins have shown promising therapeutic response.—John S. Meyer, M.D., F. Gotoh and Y. Tazaki, Wayne State University College of Medicine, 1961 WSU Symposium on Blood.

The Foreign-Trained Intern In the Emergency Room

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IN RECENT MONTHS, there has been an increasing number of articles in the medical literature concerning the foreign medical graduates who have been serving in our American hospitals. Much has also been written in the public press regarding the lack of qualifications of these foreign medical graduates with certain extreme instances being described somewhat luridly. It is obvious that this has created a grossly distorted view of the foreign medical graduates as a group in the minds of many.

The Emergency Room, with its wealth of widely divergent traumatic cases, represents an excellent milieu in which to observe the foreign medical graduate and his interpersonal relationships with patients and their families, nursing personnel, residents and attending staff.

The Patient.—Here we have an individual who has been faced with the unexpected; in this case, personal injury. The injury may be of greater or lesser significance medically, but his response to the trauma will be affected greatly by the decisions and actions of the doctor in the Emergency Room—here, the foreign-trained intern. From this first encounter with hospital personnel, a lasting impression is created which may have an important bearing on the subsequent course and final outcome of the trauma. It is here that hospital, and in many cases medical, public relations begin—or end. Since this mutual encounter between the intern and the patient is of such great importance, let us examine some of the problems involved.

Communication.—The crux of the problem is communication. The foreign-trained intern, though he may be schooled in basic English and even medical terminology, is being deluged with colloquialisms both from patients and from his colleagues. The patient will soon become aware of the intern's inability to establish communication with him and may unjustly and incorrectly conclude that the doctor is incompetent. This leads to an uncooperative patient. In turn, the foreign-trained intern may become disgusted and frustrated and proceed to errors of omission or commission. X-rays may not be taken or misread; injuries overlooked or minimized, and resident or staff consultation neglected. The patient and his family may not be told or be given an inadequate explanation—again owing to unsatisfactory communication. This may bring on an increase in the anxiety and apprehension of the patient, either directly or through the projection of anxieties and tensions by the patient's family. This vicious circle serves only to increase, psychologically at least, the effect of the trauma on the patient.

The Family of the Patient.—In considering the family, we find that unless they have had previous (and favorable) experience with hospitals, they are inclined to panic and remember all of the unfavorable stories they have ever heard about hospitals. Having arrived at the hospital, they are relieved to have someone look after the patient, but anxiety again mounts while waiting to hear the doctor's report, especially if they are forced to wait for some time because there are cases of a more serious nature being treated. Frequently the reason for the seemingly long delay is that the intern is waiting for x-ray or laboratory reports. A word to the family that such is the case would reduce their tensions, as well as remove the possibility of their falsely concluding that the doctor is sitting around and neglecting the patient. Failure to do this adequately will result in a further deterioration of relations. Another reason we cannot overlook the family is that all too frequently they are far more upset than the patient himself, and this anxiety will be conveyed to the patient, to the detriment of patient-physician relationship. This family concern is a natural thing and often the question of expenses, insurance coverage, loss of time on the job,

and the like, will be a basic cause of their upset. The intern, of course, cannot help them here, but he *can* understand and take this into consideration.

The Nurses.—As a group, we can say that the Emergency Operating Room nurses are well trained and have considerable service and experience in the emergency room. These nurses have daily contact with the type of trauma usually seen in the Emergency Room and frequently have the opportunity to observe treatment procedures carried out by the various specialists. As a consequence, although they are not physicians who diagnose, and prescribe, they are none-the-less in a position to aid the intern. Often, this is done by a pertinent remark which may steer the bewildered intern in the right direction.

At some time during their early training, most American doctors have come to appreciate these abilities of the nurses and have relied heavily on their experience. Foreign-trained interns would also do well to listen to, and value the nurses' experience. However, in many of their countries of origin, women in general do not have the personal and/or the professional status enjoyed by American women. As a consequence, the foreign-trained intern, at least early in his American experience, tends to minimize, disregard, or even resent the well-intentioned and often pertinent remarks of the nurse. This unfortunately creates friction, undermines, and may even lead to the disintegration of the doctor-nurse team and, of course, may affect the care which the patient receives in the Emergency Room.

Another point to consider is that the nurse is responsible for carrying out many procedures not strictly medical—such as inquiring into the insurance status or ability of the patient to pay. Today in most large cities there are one or more municipal hospitals servicing different sections of the city. In the case of the indigent patient brought into the Emergency Room of such hospitals, it is the responsibility of the nurse to determine whether or not the particular patient is eligible for treatment at that hospital.

This concept of financial responsibility for patient care as applied to the hospital may be completely alien to the practices in the home country of the intern. It follows then, that the professional frustration felt by the foreign-trained intern—understandable in itself—may be vented upon the nurse. In turn, the Emergency Room nurse, after a time, ceases to offer advice and assistance and another vicious circle begins to operate.

The Foreign-Trained Intern and Resident Relationship.—The intern-resident relationship should ideally be one of close cooperation and mutual assistance. This relationship often falls short of the ideal when the intern involved is a foreign medical graduate. The reasons for this are not always obvious. Even though a resident may not have had previous personal contact with foreign-trained interns, the ground work for his attitudes has been laid by his own cultural background and environment and by the comments of his fellows on their own experiences. Less obviously, the American resident, wrapped up in his own problems, may fail to consider the cultural differences and adjustments previously mentioned. As a result, the foreign-trained intern has been tried and found wanting before he even sets foot in the hospital. When the resident has had previous experience with foreign-trained interns, he generalizes from this experience and projects onto the incoming group the combined shortcomings of those who preceded them.

The foreign resident, on the other hand, has himself experienced these difficulties and might be expected to be somewhat more sympathetic towards the foreign intern; he would logically be the one who could act in a liaison capacity. This is not always the case—the explanation for which is three-fold: (1) Their individual cultural milieus are often widely divergent and may even be antagonistic. (2) Having passed through the difficult period of internship themselves and having been accepted as peers, they fear identification with the training level of the foreign intern. (3) As the foreign resident with the passage of time becomes more acclimated to both the culture and the practice of medicine, in the United States, he forgets the problems which he himself faced earlier.

Finally, both foreign and American residents often fail to recall their own unsureness and relative paucity of medical knowledge at the intern level.

The foreign-trained intern, at least during the first few months of his training in the United States, is faced with an entirely new concept of the practice of medicine. During this period it is essential that he be more closely supervised and guided by the resident. This will entail, many times, a conscious effort by the resident to be present in the Emergency Room, though he may have other duties elsewhere; and unless this effort is made, the foreign intern may be left to flounder about, unsure of himself and unfamiliar with the routines and equipment of the Emergency Room.

Two additional factors which must be considered

are the age and previous experience of the foreign-trained intern. For some, this may be their first experience with the doctor-patient relationship on an individual basis and they may need all the help that they can get from the resident. For others, who are older and who may have been in practice for several years in their own countries, quite the reverse may be true—at least, in their own minds. They may have encountered the particular problem many times at home and feel themselves quite capable of handling the situation in their own way without help or "interference" from the resident even though "their own way" may not be acceptable treatment in this country. The resident will shortly hear of this from an irate staff physician and, in turn, pass it on to the hapless intern in the same fashion—thus, further straining relations. The "old hand" will retort: "This is the way I have done it" while his younger colleague will say, "This is the way I was taught." At this juncture, the resident must either teach the accepted practice or expect repetition of the same situation.

The Resident as a Teacher.—This brings us to the role of the resident as a teacher, a role all too often overlooked or perfunctorily dismissed on the rationalization that the foreign-trained interns are not interested or they would "stick around a little more." Exploring this further, we find that, as previously noted, the resident starts off with a preconceived notion about the capabilities of the foreign-trained intern. Next, he finds that some "simple" (simple to him after several years of residency) case has been mis-diagnosed, mis-treated or perhaps an uncertain intern has called on him for assistance. The resident then proceeds to correct this situation, but fails to explain to the intern where the error occurred and teach him the correct procedure. Frequently, the resident complains that he "Couldn't teach the intern—he disappeared." It sometimes happens that the resident "chewed him out," (perhaps in front of the patient or nurses) and this is, for the intern anyway, enough reason to "disappear." Then too, perhaps the resident has a reputation for not teaching. This is not rare. Does the resident call the intern later to see a case where the cast has been placed improperly or a laceration poorly closed and equally does he commend him on a job well done? These questions could apply to any resident and any intern. When we add to this the cultural and linguistic problems and the general lack of consideration of these by the resident, we are forced to conclude that if the resident complains that he cannot teach because the interns have no incentive to learn, he more than likely has not given any thought to the part he may have played in destroying the intern's motivation.

The Foreign-Trained Intern-Resident-Staff Relationship.—Residents, by and large, reflect the attitudes of the staff physicians and, therefore, statements made regarding the foreign-trained intern-resident relationship applies basically to foreign-trained intern-staff relations. But if the residents reflect the attitudes of the staff, then it would appear that with individual exceptions, the staff are the ones who set the "climate" of the hospital inter-personnel relationships.

The foreign medical graduate comes to the United States to receive further training in medicine. By law, the foreign physician, irrespective of his previous training and experience, must serve an internship in an approved teaching hospital. Staff members, therefore, are responsible for the education of both resident and intern, but too many shirk this responsibility or rationalize that teaching the intern is the job of the resident. This is only partly true.

In the first place, the resident, by definition, is himself still in training and can learn as much or as little as the staff physicians are willing to teach. Thus, the intern in the Emergency Room calling a resident for consultation is, at best, getting "filtered experience." The resident may decide to call the staff man at once. The case then changes hands. If the staff man decides to teach, the resident may learn something; but will the intern? If he is fortunate enough to be an intern for whom the staff man has some regard, he may actually be invited to participate in the learning experience, but in far too many instances he is present only because another pair of hands is needed.

In the second place, foreign-trained intern-staff relationships are already strained for the following reasons:

1. An unfortunately large percentage of the staff physicians are unwilling to devote a few hours per week to teaching. As one foreign-trained intern put it, "They are in too much of a hurry to scamper back to their office to see more patients, and are unwilling to spend even a few minutes explaining *what* and *why*."

2. Although the internship is supposed to be more of a practicum for the knowledge absorbed in medical school, it is in fact, for reasons previously cited, far more of a "new learning" experience for the foreign intern and initially, at least, he is eager for knowledge and expects something besides "scut work."

3. Many foreign-trained interns have taken two years of internship either because they failed the Educational Council for Foreign Medical Graduates (ECFMG) examination or because they realized that they could not pass the examination and did not take it, preferring to spend another year in preparation. The examination, of course, is supposed to test basic medical knowledge but to this must be added, "as taught in the American medical schools." Failure of the residents and staff physician to teach increases anxiety and is regarded with bitter resentment. How can the foreign-trained intern possibly learn "the American way" if no one is willing to teach him? The residents and staff doctors argue that they are not medical school professors. This is true. Recently, however, the medical profession has evidenced increasing concern over the qualifications or lack thereof, of the foreign medical graduate. Yet, it is these same persons who so blithely fail to accept the responsibility which they, of their own volition, incur when they accept foreign medical graduates as interns and residents.

It seems also that many regard the foreign-trained intern as a cheap and useful convenience and consider his future of no concern to them. What little twinges of conscience they might have about not teaching American interns rapidly falls by the wayside when the foreign-trained intern comes along.

Conclusions

The purpose of raising these issues has not been to condemn American hospital attending staffs and residents *per se*, but to demonstrate via the foreign-trained intern serving on Emergency Room service, the underlying cause of the "vicious circle"—the effects of which are familiar to the entire medical profession in America.

Although the requirements of certification will, in large part, do away with many of the problems which have inadequate medical education as their base, we shall, as long as we accept foreign medical graduates into our training hospitals, continue to be faced with the misunderstandings created by cultural and linguistic barriers.

We offer no easy solution; the problem is far too complex for that. We do, however, suggest that a serious effort in the direction of assistance for, and acceptance and understanding of, the foreign medical graduate—both personally and professionally—will go a long way toward reducing many of these conflicts.

Summary

Emergency Room rotation is frequently emphasized as that portion of the internship in which the intern assumes the greatest amount of direct responsibility for patient care. An attempt has been made to analyze the problems encountered by the foreign medical graduate in the setting of the Emergency Room. It is noted that these basic problems cannot be isolated within the Emergency Room itself. Rather, the intimacy of the Emergency Room provides, in effect, a microscopic view of the problems found on all other hospital services, and the conclusions drawn also apply to these other departments to a greater or lesser degree. Analysis of the problem showed that the difficulties are primarily based on:

1. Inability of the foreign medical graduate to communicate adequately.
2. Problems of adjustment and acculturation.
3. Intern-resident-staff relations.

SS Hope Successful

"In its first six months of operation in the Island nation of Indonesia, the success of the *SS Hope I* has been outstanding," according to William B. Walsh, M.D., president and founder of Project HOPE.

Dr. Walsh reported the vessel has made nine stops to help teach and train Indonesian medical personnel. American medical personnel have performed 600 operations and seen 16,000 patients, both aboard the floating medical center and at shore-based facilities.

"One of the main purposes of the *Hope's* visit to Indonesia, and any other nation to which it will go in the future," Dr. Walsh said, "is to up-date the medical knowledge of the local people. In this respect, 800 classes, lectures, seminars and meetings were held in the classrooms and lecture halls aboard the ship during this first six months."

Outpatient Use of Librium in Psychiatric Disorders

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THE RAPID DEVELOPMENT of the psychotherapeutic drugs over a very short period of time has resulted in a near over-abundance of chemical agents available for the treatment of certain types of psychic, emotional and character disorders, from mild to severe and even vegetative. Nevertheless, this seeming plethora can be reduced for practical purposes to less than a handful, actually to two basic groups: the psychic energizers, which are primarily amine oxidase inhibitors, and the tranquilizers, principally reserpine, meprobamate or phenothiazines.

It would seem that a saturation point has been or must soon be reached in the effectiveness and multiplicity of different forms of these primary groups. When this occurs, still another name added to the list is usually greeted by the practitioner with a yawn and laboratory research is oriented away from further "molecule manipulation" and more strongly toward the development of a compound possessing new qualities and greater effectiveness for the same or similar indications. When claims for such a compound are first made, there is inevitably a certain amount of skepticism expressed by clinicians, who (1) may doubt that the drug is essentially different, (2) are understandably loath to abandon already proven, if not perfect, medications, and (3) are from experience worried about toxic and side effects from a relatively unknown product.

Prior to our use of the drug, we entertained all of these reservations with respect to Librium. It was considered, however, that if proper care were taken to observe undesirable reactions, the opportunity to evaluate its comparative therapeutic effect outweighed any question as to its unique chemical structure. In addition, both laboratory and clinical studies revealed a very low and apparently dose-related incidence of side effects,[1] and the drug's effectiveness as reported in fourteen published papers[2] indicated compensation in the patient for the omission of older medication that otherwise would have been employed during the trial period. Finally, only patients who had been checked and found in good physical condition would be made a part of the trial series.

With these conditions satisfied, it was decided to apply Librium in a number of individuals with psychiatric disorders, and since they were out-patients, to exclude from the series any patient who could be considered acutely psychotic.

Method and Material

Over a four-month period, forty-six male outpatients, aged twenty-three to sixty-three, were treated with Librium, a few after hospitalization for very short periods. Thirteen patients were psychotic and all were checked physically and found to be in good physical condition, with normal findings in routine blood examinations and urinalyses. These physical examinations, complete blood counts and urinalyses were repeated every two weeks during treatment.

For at least ten days before Librium was started, the patients were without any medication, and displayed the following signs and symptoms for which the drug seemed to be indicated: agitation, anxiety, tension, worry, fear, apprehension, panic state, anxious expectation, hypochondriacal ideas, elation, sadness and (occasionally) unpredictable behavior. For purposes of generalization, the patients were classified into three groups: (1) psychoneurotic, (twenty-eight) with anxiety, phobic or dissociative reactions, (2) psychotic,

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Librium is the trade name for chlordiazepoxide, Hoffmann-La Roche, Inc., Nutley, N. J.

(thirteen) involutional and schizophrenic, schizo-affective, and (3) cyclothymic personality, (five).

Duration of therapy was two to four months, with starting doses (10 mg. b.i.d. to 10 mg. q.i.d.) continued for from one to three weeks and maintenance doses (10 mg. b.i.d. to 10 mg. t.i.d.) for the remainder of treatment. The most common daily doses were 30 mg. initially and 20 mg. thereafter.

The patients were observed and questioned periodically to determine the appearance of any toxicity or side effects from the drug.

TABLE I. RESULTS OF TREATMENT WITH LIBRIUM
(46 Patients)

Diagnosis	Daily Dosage (mg.)			Therapeutic Effect			Total No. of Patients
	Initial	Duration (Weeks)	Main-* tenance	Good	Fair	None	
Psychoneurotic disorders							
Anxiety reaction	30	2-3	20	8	2	2	12
Phobic reaction	30	2-3	20	4	4		8
Dissociative reaction	30	2-3	20	6		2	8
Psychotic disorders							
Involutional	20-30	1-3	20	6	1	1	8
Schizophrenic, schizo-affective	20-40	1-2	20-30	2	1	2	5
Personality disturbance							
Cyclothymic	30-40	2	20	3	1	1	5
Totals				29 (63%)	9	8	46
				83%			

*Minimum duration was 2 months.

Results

Judged on the basis of our experience with other drugs, together with post-treatment absence or diminution of the previous signs and symptoms of illness noted above, Librium was therapeutically effective in thirty-eight (83 per cent) of the forty-six patients, with pronounced benefit in twenty-nine or 63 per cent (Table I).

Of twenty-eight patients with psychoneurotic disorders, eighteen achieved good results, six fair, and only four failed to respond favorably.

Good results were obtained in eight of the thirteen psychotics, fair in two, and none in three. If only those with involutional reactions are considered, however, seven out of eight improved, six markedly.

There was good therapeutic effect in three of the five patients presenting cyclothymic personality disturbances, fair in one and no effect in one.

Repeated examinations revealed no adverse effects on the patients' physical condition and bi-weekly blood counts and urinalyses remained within normal limits throughout the study.

Side effects were all very mild and experienced only during the early stages of treatment. They consisted of drowsiness with ataxia in ten patients, drowsiness alone in four, constipation in eleven and increased appetite in nine. All of these mild side effects disappeared in a few days during adjustment to the medication.

Comment

Quite apart from the relatively high percentage of effectiveness for a psychotropic drug, the results with Librium were qualitatively such as to dissipate our initial reservations concerning its uniqueness of action: we did indeed find it to be a new and "different" drug. The prompt and sustained remission of symptoms was often dramatic, an effect which was equally apparent to the patient released from his anxiety and fears and, objectively, to the observer—the previously resistant individual being readily approachable through clearer insight into his problems. Patient enthusiasm for the drug rendered treatment progressively simpler. It is difficult to attribute this salutary response merely to a placebo effect of a new drug since improvement, once achieved, was sustained over the two-month to four-month periods of treatment. The lifting of tension, agitation and apprehension and the disappearance of hypochondriasis and unpredictable behavior were both unequivocal and persistent.

A point of interest is the fact that the incidence of improvement was approximately of the same magnitude in the three diagnostic groups under study. Since the mechanism and site of action of Librium are as yet undetermined, this fact is academically provocative, but is clinically useful in that it indicates the wide range of applicability of this drug.

Another aspect of our experience with Librium

which may appear to be incidental but has important implications for the clinician, is the fact that any qualms we may have felt as to the safety of the drug turned out to be completely unfounded. Only the mildest of side effects, and these temporary, were encountered.

Since the dosage schedules were all within the recommended range for mild to moderate anxiety and tension,[3] our observations do not of themselves apply to the higher doses—double the ones employed—suggested for severe cases. At the same time, it may be that with the latter the results would have been even better in some of our more difficult patients. It would also appear that with higher doses, ambulatory patients should be carefully counseled as to the possible occurrence of ataxia and drowsiness.

Summary and Conclusions

1. Over periods of two to four months, Librium in dosages recommended for mild to moderate illness, was found to be therapeutically effective in thirty-eight (83 per cent) of forty-six male patients with psychoneuroses, psychoses and personality disturbances. Marked benefit was noted in twenty-nine, or 63 per cent.

2. Bi-weekly blood counts and urinalyses remained within normal limits throughout the study.

3. Side effects of ataxia, drowsiness, constipation and increased appetite were reported, but all instances were mild and disappeared during adjustment to the medication.

4. It is concluded that Librium was a useful medication in helping patients to obtain better emotional balance and insight, especially the psychoneurotic patients and those presenting signs and symptoms of involutional reaction. Its persistent beneficial effect in patients who responded well is especially noteworthy.

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Ribicoff Afraid of Debate?

Battle Creek Enquirer-News, May 22, 1961

Abraham Ribicoff, secretary of health, education and welfare, owes the American Medical Association —and the public—a better explanation than he has given so far for accepting and then rejecting an AMA challenge to debate the issue of financing health care costs of the aged.

In a recent letter to Mr. Ribicoff, Dr. F. J. L. Blasingame, AMA executive vice president, accused Mr. Ribicoff of unjustly criticizing the medical profession and making misleading claims about the Kennedy administration's new health insurance plan for the aged. The AMA contends that the measure, known as the King bill, is nothing more than socialized medicine. Mr. Ribicoff says it is not.

The AMA certainly has logic on its side in saying that this controversy has confused the public. In its letter to Mr. Ribicoff, the medical association said, "It is our hope that Mr. Ribicoff will agree to a nationwide (televised) debate to end the continuing claims and counterclaims concerning the administration's proposal."

In his reply, Mr. Ribicoff apparently agreed on this point, for he advised the AMA that "I think it highly desirable that there be a full discussion of this important issue so that the public may be fully informed of the facts."

The AMA went into action immediately and selected Dr. Edward R. Annis of Miami as its spokesman. Mr. Ribicoff then refused to debate the issue, arguing that he should be permitted to choose his own opponent.

It must be admitted that the AMA rolled out its biggest gun in selecting Dr. Annis, who is a skilled and most articulate logician as well as a fine doctor. Dr. Annis recently debated Walter Reuther and Sen. Hubert H. Humphrey (D-Minn.) separately—although he probably could have taken on both simultaneously—on medical care plans. There is little doubt that both Mr. Reuther and Sen. Humphrey, who are also veterans of debate, were quite surprised to discover a doctor who could stand up to them in argument.

In view of this, Mr. Ribicoff's trepidation in confronting Dr. Annis may be understandable, but it is not excusable. He has been challenged to debate a vital issue. He has refused on the most specious of grounds. Is he afraid to lay his case for the King bill before the public where it can be examined by a recognized expert on the subject? It seems that he is.

Congress should take full cognizance of this incident. If Mr. Ribicoff will not face the AMA challenge, then it must be assumed that there are hidden weaknesses and, perhaps, perils in the bill that should be exposed forthwith.

The Repeat Shirodkar Operation

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IT HAS BEEN very interesting for obstetricians in the past decade to observe the discovery of a new clinical syndrome—the incompetent internal cervical os, and to participate in the development of efficient methods of treatment. There is still little agreement as to the best method of handling these cases. I would like to report a new way of managing this problem: namely, repeat Shirodkar procedures in the same patient with vaginal delivery each time. To my knowledge, this method of treatment has not been previously reported, although it has been used for some time by myself and several other Detroit obstetricians, as well. It has definite advantages over other methods, and in my opinion deserves wider use.

Case Report

Mrs. A. P. (Case No. A-41048) was a twenty-year-old $P_0G_2A_2$ who first came to the office on July 28, 1958, with a chief complaint of amenorrhea, her last menstrual period having been on June 1. She stated that she had had two previous miscarriages, one at three and one-half months in 1952 and the other at four and one-half months in 1953. Both pregnancies were confirmed by a physician, but neither time did she have a dilatation and curettage. Pelvic examination now disclosed the uterus to be slightly enlarged and softened, and a Kupperman test was positive. A diagnosis of normal intra-uterine pregnancy was made with an expected date of confinement of March 11, 1959. She did not return again until October first, at which time the cervix appeared non-effaced and non-dilated; on October 22 the cervix again appeared normal.

However, on October 27 (now twenty-one weeks pregnant) she complained of mild lower abdominal cramps and a watery discharge; she was examined and the cervix was 4 cm. dilated and completely effaced with the membranes bulging at the external os. Despite immediate hospitalization and a Shirodkar procedure the next day using polyethylene tubing, she developed a purulent vaginal discharge on the nineteenth postoperative day and went into premature labor. After the suture was cut, she promptly delivered a one-pound fetus which lived only a few hours. She returned on November 2, 1959, again pregnant, stating that her last menstrual period had been on September 11. On November 9 she began spotting vaginally and was treated with bed rest and one of the oral progesterones* 10 mg. b.i.d.; this was reduced to 10 mg. daily in four weeks, and then to 10 mg. every other day for another four weeks. At nineteen weeks of gestation, she was admitted to the hospital for a Shirodkar procedure (a double ligature was used—one of polyethylene tubing and also a Mersiline ribbon). Her prenatal course was normal thereafter until the thirty-second week when she went into premature labor. She was hospitalized, both ligatures were cut, and in one hour she was delivered vaginally of a normal two-pound fourteen-ounce boy who survived.

Discussion

Diagnosis.—If one is aware of this still-rare condition, diagnosis presents little difficulty. It is best made from the typical history and/or observation of the cervix during the strain of pregnancy. X-ray methods[7] are difficult to perform and interpret, are time-consuming, and unnecessarily expose the patient to irridiation. Ability of the non-pregnant internal os to pass a No. 8 Hegar dilator without pain should be only confirmatory and not the main point in diagnosis (especially since these cases are best repaired during subsequent pregnancy, anyway).

Repair.—Corrective surgery for this condition is best done during each successive pregnancy. These patients must be watched closely (weekly) from the twelfth to the twenty-fourth week even if they have had a previous Lash procedure (failure of the Lash

*Enovid

From the Departments of Obstetrics and Gynecology, Highland Park General and Critten General Hospitals, Detroit.

The Author

ANDREW F. CAUGHEY, JR.
M.D.



with the need for secondary repair during pregnancy has occurred[9]). Further, surgical correction during pregnancy is much easier than the Lash, there is much less blood loss and operating time, and one need not worry about secondary infertility or cervical stenosis with hematometra from a too-tight repair. Another problem is the increased mobility of patients nowadays. What if the patient moves and forgets to notify her new obstetrician that she has had a permanent type of repair? Rupture of the uterus[6] and death of the patient from complications[3] have already been reported in patients during labor with permanent cervical repairs. If the suture is removed each time prior to delivery by the same physician who inserted it, there is no such danger.

Delivery.—These babies are best delivered vaginally and cesarean section should not be used. They are often premature[5] in spite of corrective surgery, and vaginal delivery is safer for them. Also, after the suture is cut, labor is typically rapid and easy for the mother and child. Further, in these days of rising section rates (largely due to increased numbers of repeats) one should try to avoid unnecessary primary sections. Finally, if a permanent type of cervical repair were used, how would premature labor "or abruptio" at (say) thirty weeks' be handled? With a removable suture, this is no problem.

Type of Operation.—The best type of operation to use during pregnancy is still controversial. There are two methods of surgery used: namely, various types of the Shirodkar procedure,[2,8] and "bridge" tracheloplasty.[1] At first, many surgeons were elevating the bladder flap to place the purse string suture (in the Shirodkar); lately in my hospitals,[4] the tendency has been toward a simpler procedure such as the McDonald technique.[5] This is much easier and causes less scarring, blood loss and operating time. Preferences for suture materials still vary, although polyethylene and Mersiline are most popular now. In my opinion, more attention should be paid to the postoperative care of these patients. Definite restriction of out-of-house activity, proscription of intercourse, the use of maternity garments, antibiotic vaginal creams, and daily rest periods—all are helpful in prolonging pregnancy. Perhaps the tracheloplasty advocated by Baden and Baden[1] will yet become the treatment of choice. However, it is not known yet whether this procedure can be repeated, and how it compares with the Shirodkar in strength, rate of postoperative infection, and percentage of success. It certainly has the advantage that the patient's own (cervical) tissue is used in the repair, and not a foreign substance, however bland.

Summary

1. A case of repeat Shirodkar procedure in successive pregnancies in the same patient is reported.

2. Repair during each pregnancy with subsequent vaginal delivery after removal of the suture is recommended as the treatment of choice in this type of case.

3. The best type of surgical procedure to use is still unknown; however, at the present time, I favor the Shirodkar procedure using polyethylene tubing with black silk threaded inside it.

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7. Rubovits, F. E., Cooperman, N. R., and Lash, A. F.: Habitual abortion: A radiographic technique to demonstrate the incompetent internal os of the cervix. Am. J. Obst. & Gynec., 66:269, 1953.
8. Shirodkar, V. N.: Surgical treatment of habitual abortion. International Congress of Gynecology and Obstetrics, Geneva: Librarie de l'Universite, 'Georg et Cie, S.A., 1955.
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Discovery that body cells which produce bone can also produce cartilage or fibrous tissue is announced by the Easter Seal Research Foundation. The project has been supported by a grant from the Easter Seal Research Foundation of the National Society for Crippled Children and Adults. A research team at Columbia—Presbyterian Medical Center in New York found in a series of experiments that it is possible to grow fibrous tissue and cartilage as well as bone from bone cells.

Jet Age Medicine

The medical profession of 1961 with its independent type of practice as it exists in America today, is making strides in research, facilities and in abilities, and movng just as fast in our very strictly important field of knowledge as the transportation, communication and engineering facilities which astonish the rest of the world. The nuclear science age has contributed its help to medicine. These various fields have made possible the mysterious and marvelous surgery we all know could never have been done even two or three years ago.

All of these things cost money—actually they cost wages. They have produced an increasingly healthy and capable generation of people who will live longer and whose working potential has made it possible to produce all the services, appliances, supplies and demands which we need.

Unfortunately, we still have an increasing number of unemployed —by choice or necessity. At any rate fewer people are constantly expanding production facilities to the point of eliminating actual need in any area in the United States. Our Agricultural Department, or the government is hoarding increasing reserves that would feed us for several years.

Modern Science Progresses

One item, transportation, shows that we are living in a constantly changing age. Jets are now taking us all over the world at the speed of sound and more. Communications have increased so avidly that if we have the telephone numbers and the key, we can call anybody, anyplace, from our own dial telephone. A T & T is actually transferring messages around the world by bouncing them off the "ECHO." A T & T has asked the federal authorities for permission to put 30 of those "moon" satellites in orbit so as to complete its communication facilities. All this accomplishment is the result of education, research, and study in our college and university centers.

Education We Must Afford

The needs of education in general have greatly increased during the years for a very simple reason. We have a great mass of new knowledge, facts, facilities and accomplishments which must be taught to our young people before they are able to take over the administration, guidance and function of our society.

In every field of endeavor, new discoveries and research have pointed the way for more intensive education, for greater numbers. The state of our colleges testifies to this fact with their phenomenal growth. The state-supported universities: The University of Michigan ferring messages around the world by bouncing them off the moon education, research and study in our college and university centers. and Michigan State University have been with us a long time. Wayne State University which has recently been taken over by the state, was formerly supported by the Detroit Board of Education. This makes three great state-supported Universities each with registrations crowding the 25,000 mark. Each has its own separate board of administrators.

Three other colleges have assumed University status under the administration of the State Board of Education: Western Michigan University in Kalamazoo, Eastern Michigan University at Ypsilanti, Cen-

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tral Michigan University at Mount Pleasant. Each of these have now nearly 10,000 students. All six institutions recently announced limitations of admissions, and increases of tuition.

Another problem Michigan is facing will greatly affect the medical profession. For many years, there has been agitation for more medical graduates, charging the profession with holding down numbers. Much MSMS effort over a number of years provided for an increase of 75 to 125 doctors to be graduated from Wayne State University each year. The entering class, 1958, was authorized to accept an additional 25 students. These were cancelled suddenly, applying to the entering class in 1962. The medical profession and the people will suffer because these 25 young prospective doctors will fail to start their course this fall.

Private Industry

Through private industry, the United States has been able to provide all of its mechanics, housing, food, clothing and health needs and leave a reserve. This has been done by paying salaries and wages. About 72 per cent of the cost of operating a hospital is wages. That same figure holds, generally, for all medical and health services. Labor has complained that medicine and health insurance is pricing itself out of reach and that costs are too high. This is not true. The costs are high, but we are living in a jet age where all other costs are just as high. Medical, health and hospital services will compare with all the others in the matter of increased costs.

How many of our critics, whether labor or industry or the Insurance Commissioner, would have us go back even five years in our facilities?

One question is most important: "Is what we are doing worth it?" If it is, the public will meet those costs as it does all others. If anyone actually believes otherwise, all he needs to do is to follow through with the proposed legislation now in Congress, putting medical and hospital care under the Social Security program. There would be no further advance in the skills and in the research as soon as we put this whole program within the jurisdiction and administration of political bureaucrats in Washington.

England went through this about 15 years ago and in that length of time, they have constructed only one new hospital of 35 beds. Anybody under that program who needs elective surgery must wait from 15 months to two years. Only emergencies are taken care of immediately and the cost of the plan over there has increased five times as much as was anticipated. Doctors available for services have gradually decreased—some moving elsewhere, others not going into medical training.

Comparative Costs and Coverages

Certificates of Michigan Blue Shield coverage of "over 65" persons have been authorized and sold for about two years. After the passage of the Kerr-Mills Bill by the federal Congress in the summer between nominations and elections last year, these contracts became more operable. The Michigan legislature immediately adopted the necessary laws allowing the Michigan eligibles to benefit, and provided that services and benefits correspond to Michigan Blue Shield and Blue Cross. This law is administered by the Michigan Department of Social Welfare.

Michigan's policies for "over 65" persons went into more favorable acceptance. They cost each person $8.47 per month, or $101.96 a year ($5.23 Blue Cross, $3.24 Blue Shield per month). These rates have not been changed by the recent adjustments. They furnish subscribers the Blue Cross-Blue Shield coverage of the $2,500 Plan A, M-75 contract. This includes, at this income level, 30 days in hospital, medical care, surgery, anesthesia and first aid. The usual Class II benefits under the M-75 program are also included. No obstetrics or maternity benefit is provided. The Blue Cross contract is a 30-day contract. Under this hospital contract, each member pays the first $25, or 20 per cent of the first $500 of each hospital bill.

Now compare this with the King-Anderson Bill (HR 4222) being pushed by the Administration as hospital and medical coverage for the beneficiaries of Social Security—this to be added to Social Security for every beneficiary no matter what his income. Actually what will be given, under rigid restrictions is 90 days hospital care, the patient to pay the first nine days at $10 a day, with a minimum of two days. If the patient is to have diagnostic care he must pay the first $20. New admissions after 90 days must be considered as new cases.

Under this plan the patient could pay $110 for each hospitalization. For very limited services he will have paid almost one month's charges more than Blue Cross-Blue Shield's yearly charge.

One hospitalization experience will demonstrate to the beneficiaries that they have been sold down the river.

SERVICE TO ALL

"Let us continue to provide for all citizens, irrespective of age, the privilege to die on their feet and not to live on their knees."

That is the closing statement made by Frederick C. Swartz, M.D., Lansing, chairman of the AMA Committee on Aging, in the April number of "Michigan Challenge," publication of the Michigan State Chamber of Commerce.

Annual Session Speakers, 1961


E. E. Aegerter, M.D.


Wm. Altemeier, M.D.


Ivan C. Berlien, M.D.


R. J. Bing, M.D.


M. R. Caro, M.D.


W. S. Derrick, M.D.

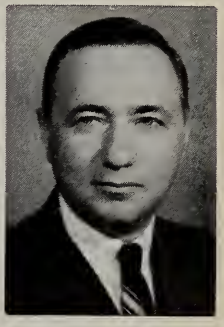

L. P. Dodd, LL.B.

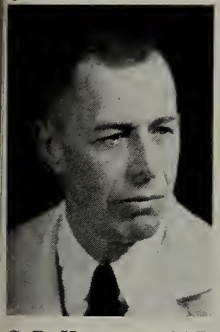

W. G. Fox, M.D.

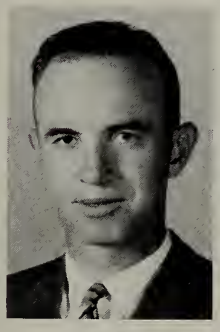

J. R. Gallagher, M.D.

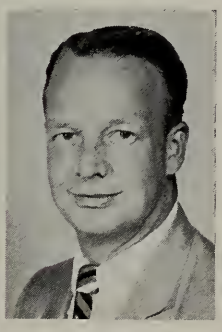

Richard Gorlin, M.D.

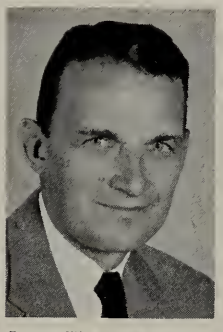

R. B. Greenblatt, M.D.


S. B. Gusberg, M.D.

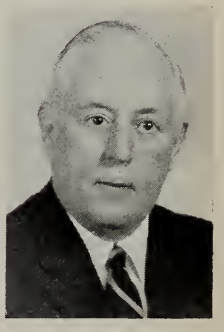

C. D. Haagensen, M.D.


L. C. Hampson, M.D.

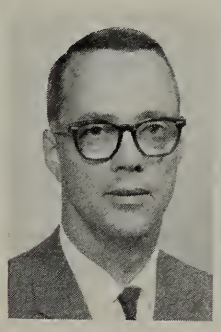

E. R. Harrell, M.D.

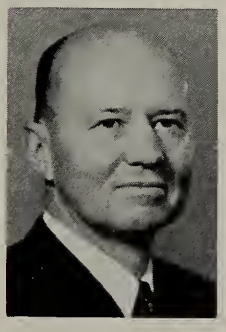

J. R. Haserick, M.D.


C. V. Hodges, M.D.

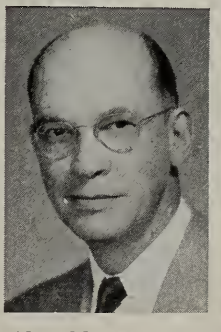

Carl P. Huber, M.D.


F. D. Lathrop, M.D.


G. S. Lodwick, M.D.


L. C. McGee, M.D.


A. D. McLachlin, M.D.


N. F. Miller, M.D.


John H. Moyer, M.D.


M. J. Nechtow, M.D.


H. R. Reichman, M.D.


B. R. Straatsman, M.D.


H. H. Stryker, M.D.


T. A. Watters, M.D.


J. L. Wilson, M.D.

Michigan State Medical Society

The Ninety-Sixth Annual Session

Pantlind Hotel-Civic Auditorium, Grand Rapids

September 27-29, 1961

ANNUAL SESSION INFORMATION

• **DIRECTORY**

Headquarters—Pantlind Hotel—Civic Auditorium, Grand Rapids

Registration—For Scientific Session: Tuesday, September 26 through Friday, September 29, in Civic Auditorium Exhibit Hall.

Hours:
Tuesday, September 26—10:00 a.m. to 5:00 p.m.
Wednesday, September 27—8:00 a.m. to 5:00 p.m.
Thursday, September 28—8:30 a.m. to 5:00 p.m.
Friday, September 29—8:30 a.m. to 1:00 p.m.

News Rooms—For Scientific Session—Room F, and Vandenberg Room, Civic Auditorium.

Woman's Auxiliary Headquarters—Pantlind Hotel.

Michigan State Medical Assistants Society Headquarters—Occidental Hotel, Muskegon

MSMS HOUSE OF DELEGATES BALLROOM, PANTLIND HOTEL, GRAND RAPIDS

Registration: 6:00 p.m., Sunday, September 24, Lobby of Pantlind Hotel

First Meeting: Sunday, September 24, 8:00 p.m.

Second Meeting: Monday, September 25, 9:00 a.m.

Third Meeting: Monday, September 25, 8:00 p.m.

Fourth Meeting: Tuesday, September 26, 9:00 a.m.

Fifth Meeting: Tuesday, September 26, 8:00 p.m.

Delegates' News Room: Room 138, Pantlind Hotel

• **CHECK ROOM**—Civic Auditorium

• **POSTGRADUATE CREDITS ARE GIVEN TO EVERY MSMS** member who attends the Annual Session.

• **NO REGISTRATION FEE FOR MEMBERS OF MSMS AND OTHER STATE MEDICAL ASSOCIATIONS, AMA, AND CANADIAN MEDICAL ASSOCIATION.**

Admission will be by badge only to all Scientific Assemblies, Section meetings, and the Exhibition. Please present your MSMS or other State Medical Association, AMA, or CMA membership card to expedite your registration. We wish to save your time.

SECTION MEETINGS

WEDNESDAY, SEPTEMBER 27
Dermatology-Syphilology
General Practice
Medicine
Obstetrics-Gynecology
Public Health and Preventive Medicine
Surgery
Urology

THURSDAY, SEPTEMBER 28
Anesthesiology
Gastroenterology-Proctology
Nervous and Mental Diseases
Occupational Medicine
Ophthalmology
Otolaryngology
Radiology

FRIDAY, SEPTEMBER 29
Pathology and Radiology
Pediatrics

• **MICHIGAN DOCTORS OF MEDICINE,** in practice but who are not members of MSMS, if listed in the American Medical Association Directory, may register as guests upon payment of $25.00. This amount will be credited to them as dues in the Michigan State Medical Society, FOR THE BALANCE OF 1961 ONLY, provided they subsequently are accepted as members by the county medical society in whose jurisdiction they practice.

• **TELEPHONE SERVICE**—Special lines to handle local and long distance telephone service for registrants at the MSMS meetings are available in the Civic Auditorium just outside the Black and Silver Room: GLendale 1-9156; GLendale 1-9751, GLendale 1-9313. The telephone number at the Pantlind Hotel is GLendale 9-7201.

• **GUEST ESSAYISTS** are very respectfully requested not to change time of their lectures with another speaker without the approval of the Assembly Chairman. This request is made in order to avoid confusion and disappointment on the part of members of the audience.

• **TRANSPORTATION**—The C & O Streamliners afford a convenient means of transportation to the MSMS Annual Session in Grand Rapids for hundreds of physicians located in the Detroit-Lansing area of the State.

• **PARKING**—Metered parking on the streets surrounding the Pantlind Hotel and Civic Auditorium. Outside lots are available as follows.

1. Rear of Rowe Hotel (two blocks from Pantlind Hotel).
2. Campau Avenue parking lot (one and one-half blocks from Civic Auditorium).
3. Opposite Civic Auditorium.

• **THE HOUSE OF DELEGATES NEWS COMMITTEE** is composed of: J. J. Lightbody, M.D., Chairman, Detroit, H. F. Falls, M.D., Ann Arbor, C. A. Payne, M.D., Grand Rapids, D. Bruce Wiley, M.D., Utica.



H. G. Benjamin, M.D.

• **H. G. Benjamin, M.D.,** Grand Rapids, is Chairman of the Committee on Arrangements for the 1961 Annual Session.



David Kahn, M.D.

• **David Kahn, M.D.,** Lansing, is Chairman of the Program Committee for the 1961 Annual Session.



J. R. Lentini, M.D.

• **J. R. Lentini, M.D.,** Grand Rapids, is Chairman of Scientific Exhibits.

MICHIGAN MEDICAL SERVICE MEMBERS' SCHEDULE

(Coincident with MSMS House of Delegates)

Pantlind Hotel, Grand Rapids

Tuesday, September 26, 1961

12:30 p.m.—Reception, Kent State Room
1:00 p.m.—Luncheon, Kent State Room
2:00 p.m.—MMS Annual Meeting, Ballroom

All MSMS Delegates are Members of Michigan Medical Service corporation and are expected to attend the MMS luncheon and annual meeting. The MMS annual meeting is open to ALL members of the medical profession, who are cordially invited to attend.

INFORMATION OF PRACTICAL VALUE IN DAILY PRACTICE WILL BE FOUND at the Michigan State Medical Society Annual Session. All subjects on the MSMS Annual Session Program are applicable to clinical medicine. They stress diagnosis and treatment in everyday practice.

• **COMMITTEE ON PROGRAM**—David Kahn, M.D., Lansing, Chairman; Charles M. Bell, M.D., Grand Rapids; Robert E. L. Berry, M.D., Ann Arbor; Hugh W. Henderson, M.D., Detroit; Howard Robinson, M.D., Detroit.

• **THE SCIENTIFIC NEWS COMMITTEE** is composed of: H. G. Benjamin, M.D., Chairman, Grand Rapids, F. S. Alfenito, M.D., Grand Rapids, F. C. Brace, M.D., Grand Rapids, J. A. Ferguson, M.D., Grand Rapids, A. B. Gwinn, M.D., Hastings, P. W. Kniskern, M.D., Grand Rapids, C. L. Weston, M.D., Owosso.

• **THE SCIENTIFIC AND TECHNICAL EXHIBITS** will open at 9:30 a.m. on Wednesday, Thursday, and Friday; and will close daily at 5:00 p.m. except on Friday when the break-up is 1:00 p.m. Frequent intermissions to view the 130 educational displays have been arranged during, and after the Assemblies. Bring to the MSMS convention a "WANT LIST" of your needs and place an order with your MSMS exhibitor friends.

• **PAPERS WILL BEGIN AND END ON TIME**—Believing there is nothing which makes a scientific meeting more attractive than by-the-clock promptness and regularity, all meetings will open exactly on time, all speakers will be required to begin their papers exactly on time and to close exactly on time in accordance with the schedule in the program. All who attend the meeting, therefore, are requested to assist in attaining this end by noting the schedule carefully and being in attendance accordingly. Any member who arrives five minutes late to hear any particular paper will miss exactly five minutes of that paper!

NEW INFORMATION IN THE EXHIBIT

Many items of interest or education will be found in the large exhibit of 130 scientific and technical displays. The Exhibit Section at MSMS Annual Sessions is as important, informative, and desirable to most doctors of medicine as the scientific papers presented in the Assembly room.

Doctor, stop at every booth—you'll be surprised how much you'll learn. A courteous, well-informed exhibitor will greet you and supply you with some valuable information helpful to your patients.

• **THE HOLDER OF A HOTEL RESERVATION** who fails to show up . . . and fails to cancel his reservation . . . causes gastric hyper-peristalsis, hypersecretion of the hydrochloric acid, and rubus of the gastric mucosa to the hotel manager.

When convention reservations fill a hotel to the capacity, a room not occupied is a loss in $$$ that cannot be reclaimed.

The MSMS Annual Session always means a capacity house in the Grand Rapids headquarters hotel.

Be kind to the hotel manager . . . be good to MSMS . . . be generous to your patients . . . be a friend to yourself—by showing up at the hotel of your choice in Grand Rapids, for the three days of the MSMS Annual Session.

Order your hotel accommodations today

HOTEL RESERVATIONS
MICHIGAN STATE MEDICAL SOCIETY

96th Annual Session

Grand Rapids, September 27-28-29, 1961

The reservation blank below is for your convenience in making your hotel reservations in Grand Rapids. Please send your application to the Committee on Hotels for MSMS Convention, Pantlind Hotel, Grand Rapids, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Committee on Hotels by sharing a room with another registrant, when convenient.

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Committee on Hotels,
Michigan State Medical Society
c/o Jack Ament, Room Reservation Manager
Pantlind Hotel, Grand Rapids, Michigan

Please make hotel reservation(s) as indicated below:

———— Single Room(s) ————persons

———— Double Room(s) for ————persons

———— Twin-Bedded Room(s) for ————persons

Arriving September ———hour———A.M.———P.M.

Leaving ————hour———A.M.———P.M.

Hotel of First Choice: ————————————

Second Choice: ————————————

Names and Addresses of all applicants including persons making reservations:

Name	*Address*	*City*	*State*

Date ———— Signature ————————

Address ———————— City ————

A POPULAR SPORT

CASTIGATION OF AMA has become a popular sport. First it is said that AMA is always against everything, never for anything. Nothing could be further from the truth but the critics do not wish to listen. Then they condemn when positive action is taken. Latest attack came via a New York Times News Service release early this month. The story was based on an article in *The Christian Century* about the General Assembly of the United Presbyterian Church at Buffalo, New York, in May. The magazine seems to have been put out because the Presbyterian group did not endorse the Kennedy Administration's effort to put medical care of the elderly under social security. The magazine seemed to think delegates had declined to support the proposed legislation because of "misuse of truth" and lack of "courtesy and manners" by AMA. Ire was aroused because delegates to the Assembly had been given information enabling them to understand both sides of the question. Presbyterians denied that there had been any pressure brought to bear. Apparently it is meritorious to work for socialism but a sin to be opposed to it. This is typical of the castigation currently being applied to AMA. —*H.L.H.*, NORTHWEST MEDICINE, June, 1961.

THE CONTRIBUTION OF THE SCIENTIFIC AND TECHNICAL EXHIBIT

The Michigan State Medical Society has always felt that the scientific and technical exhibit is an essential part of the educational process of its Annual Sessions. A considerable proportion of medical research is sponsored by many institutions and manufacturers whose displays are part of our exhibit. Year in and year out, they make substantial contributions to progress in Medicine. This year, they offer many new ideas in therapy and techniques.

Doctors of medicine are invited and urged to inspect the exhibits, to examine products and services, and to question the exhibitors on "what's new for me to use?" Discuss with these well-trained and informed exhibitors the uses of the products of their laboratories. Sample their professional knowledge, which is an adjunct to the scientific talks and other presentations of the MSMS Annual Session, all congregated in one spot for you, Doctor, so that you may serve the public better.

MSMS Ninety-Sixth Annual Session

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William M. Tuttle, M.D., Detroit

Ways and Means

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Michigan State Medical Society

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(Died before taking office)
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1949— Wilfrid Haughey, Battle Creek
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1949—*W. E. Barstow, St. Louis
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1952—R. L. Novy, Detroit
(President-for-a-Day, Sept. 22, 1952)
1952— R. J. Hubbell, Kalamazoo
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(President-for-a-Day, Sept. 28, 1954)
1954—*R. H. Baker, Pontiac
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1958— G. B. Saltonstall, Charlevoix
1959—Milton A. Darling, Detroit

*Deceased

Michigan State Medical Society

Ninety-Sixth Annual Session

PANTLIND HOTEL-CIVIC AUDITORIUM, GRAND RAPIDS

WEDNESDAY-FRIDAY, SEPTEMBER 27-29, 1961

Programs of Assemblies and Sections

WEDNESDAY MORNING

September 27, 1961

Registration: 8:00 a.m., Civic Auditorium

Exhibits: 9:30 a.m., Civic Auditorium

First Assembly

Black and Silver Ballroom, Civic Auditorium

Chairman: HUGH W. HENDERSON, M.D., Detroit
Secretary: C. E. REDDICK, M.D., Bay City

A.M.
9:00

"MANAGEMENT OF GOUT"

ALEXANDER B. GUTMAN, M.D., New York, New York
Director, Department of Medicine, Mt. Sinai Hospital; Professor of Medicine, Columbia University College of Physicians and Surgeons

Four aspects of the management of gout will be considered:

1. Termination of acute attacks by (a) colchicine, (b) phenylbutazone, (c) oxyphenbutazone, (d) ACTH. Our data indicate that each of these drugs is effective in about 80 to 90 per cent of cases.
2. Prevention of recurrence of acute gouty arthritis by (a) prophylactic colchicine, (b) prophylactic phenylbutazone, (c) uricosuric agents. Our data indicate that prophylactic colchicine is effective in most cases, simple to administer and safe.
3. Prevention and treatment of tophaceous deposits by (a) probenecid, (b) sulfinpyrazone, (c) zoxazolamine. All of these drugs are effective uricosuric agents and of low toxicity.
4. Prevention of uric acid calculus formation. The importance of urine volume and urine pH will be stressed.

9:30

"THE CORONARY CIRCULATION IN MAN; WITH PARTICULAR REFERENCE TO THE PROBLEM OF CORONARY INSUFFICIENCY"

RICHARD GORLIN, M.D., Boston, Massachusetts
Assistant Professor of Medicine, Harvard Medical School; Senior Associate in Medicine, Peter Bent Brigham Hospital

10:00

INTERMISSION TO VIEW EXHIBITS

11:00

"WHY AND HOW TO TREAT THE PATIENT WITH HYPERTENSION"

JOHN H. MOYER, M.D., Philadelphia, Pennsylvania
Professor and Chairman, Department of Medicine, Hahnemann Medical College and Hospital

Comparison of treated and untreated patients with hypertension shows that effective reduction of the blood pressure arrests the vascular deterioration associated with hypertension in patients with severe and moderately severe hypertension. The mortality is significantly lower in treated patients than untreated patients. Renal deterioration is arrested and mortality reduced in patients with malignant hypertension, as well as in patients with non-malignant hypertension, who are treated.

A comprehensive therapeutic regimen for lowering the blood pressure is recommended. One of the thiazide derivatives (natriuretic agents) is used as background therapy since these agents not only have antihypertensive properties, but in addition, increase the effectiveness of drugs which depress the sympathetic nervous system. If the thiazide derivatives fail to produce the desired results, then the sympathetic depressant drugs, such as rauwolfia, hydralazine, and guanethidine are given in sequence until the blood pressure has been brought under adequate control.

11:30

(Subject to be announced)
JEREMIAH STAMLER, M.D., Chicago, Illinois

12:00

"PROBLEMS OF MENSTRUAL DYSFUNCTION"

ROBERT B. GREENBLATT, M.D., Augusta, Georgia
Professor of Endocrinology, Medical College of Georgia

Certain problems concerned with menstruation will be presented, namely, amenorrhea, functional uterine bleeding, idiopathic dysmenorrhea. Diagnosis and etiology of the amenorrheas will be discussed, as well as preferred methods of treatment. The hormonal management of functional uterine bleeding, endometriosis, and membranous dysmenorrhea will be covered. Techniques for the delay of menstruation and for induction of pseudopregnancy will be included in the discussion.

P.M.
12:30

END OF FIRST ASSEMBLY

MUCH THAT IS NEW AND USABLE
WILL BE FOUND IN THE
EXCITING MSMS EXHIBIT OF
130 DISPLAYS

WEDNESDAY AFTERNOON

September 27, 1961

Second Assembly

Black and Silver Ballroom, Civic Auditorium

Chairman: P. C. DiLoreto, M.D., Detroit
Secretary: H. E. Lichwardt, M.D., Birmingham

P.M.
2:00

Panel on "DERMATOLOGIC MANIFESTATIONS OF INTERNAL DISEASES"

Marcus R. Caro, M.D., Chicago, Illinois
Consulting Dermatologist, Cook County Hospital

John R. Haserick, M.D., Cleveland, Ohio
Head, Department of Dermatology, Cleveland Clinic Foundation

3:00 INTERMISSION TO VIEW EXHIBITS

4:00

"THE LIGATION OF THE HYPOGASTRIC (INTERNAL ILIAC) ARTERIES AS A LIFE-SAVING PROCEDURE IN UNCONTROLLABLE HEMORRHAGE IN OBSTETRICS AND GYNECOLOGY"

Mitchell J. Nechtow, M.D., Chicago, Illinois

Attending Gynecologist, Cook County Hospital; Associate Professor of Obstetrics and Gynecology, Chicago Medical School; Professor of Gynecology, Cook County Graduate School; Chairman, Obstetrics-Gynecology, Norwegian American Hospital; Attending Gynecologist, Northwest Hospital

4:30

"SELECTION OF TREATMENT FOR CANCER OF THE CERVIX"

Saul B. Gusberg, M.D., New York, New York

Associate Professor of Clinical Obstetrics and Gynecology, Columbia University College of Physicians and Surgeons; Associate Attending Obstetrician and Gynecologist, Sloane Hospital for Women, Vanderbilt Clinic and Francis Delafield Hospital of the Columbia-Presbyterian Medical Center

Treatment of cervix cancer must be planned individually and expertly for each patient if a maximum cure rate is to be attained, for the first therapist who undertakes the patient's care is the only one who has a possibility of effecting a cure.

The definition of cancer precursors in this region, and the promise of their universal detection by cytologic smears, makes the hope of virtual control of this disease a reasonable one.

The study of patterns of radiosensitivity of cancer of the cervix and their clinical applicability offers the prospect of integrating radical surgical treatment in a meaningful way, so that these excellent modalities may be complementary rather than competitive.

A treatment plan will be presented that utilizes modern knowledge of this disease for selective management by employing a team approach that encompasses the skills of the gynecologist, the pathologist, the radiotherapist and the radiation physicist.

5:00

"HYPERTENSION IN RENAL ARTERY LESIONS"

Clarence V. Hodges, M.D., Portland, Oregon

Professor of Surgery and Head of Division of Urology, University of Oregon Medical School

An undetermined number of patients with hypertension will show lesions, particularly stenosis, in the renal arteries. Current bases for determining which patients should undergo extensive workup for renal hypertension as indicated by pertinent facts of history, physical examination, and routine tests will be presented. A regimen for identifying and visualizing such lesions will be described. Methods for verifying the presence of such lesions, current techniques for revascularization of the kidney and results of therapy will be shown.

5:30
END OF SECOND ASSEMBLY

WEDNESDAY, SEPTEMBER 27, 1961

Program of Sections

Section on Dermatology and Syphilology

12:00 noon luncheon-meeting

Chairman: David Kahn, M.D., Lansing
Secretary: John N. Grekin, M.D., Detroit

"SERENDIPITY CONFERENCE"

Moderator:

E. Richard Harrell, M.D., Ann Arbor, Michigan
Professor of Dermatology, University of Michigan Medical Center

Panelists:

Marcus R. Caro, M.D., Chicago, Illinois
Consulting Dermatologist, Cook County Hospital

John R. Haserick, M.D., Cleveland, Ohio
Head, Department of Dermatology, Cleveland Clinic Foundation

Section on Public Health and Preventive Medicine

12:00 noon luncheon-meeting

Chairman: Vlado A. Getting, M.D., Ann Arbor
Secretary: C. E. Reddick, M.D., Bay City

(Subject to be announced)
Jeremiah Stanler, M.D., Chicago, Illinois

MUCH THAT IS NEW AND USABLE
WILL BE FOUND AT THE
MSMS EXHIBIT

Section on Obstetrics and Gynecology

12:30 p.m. luncheon-meeting

Chairman: C. M. Bell, M.D., Grand Rapids
Secretary: P. C. DiLoreto, M.D., Detroit

Panel on "CARCINOMA OF THE FUNDUS"

Moderator:

Norman F. Miller, M.D., Ann Arbor, Michigan
Professor of Obstetrics and Gynecology, University of Michigan Medical Center

Panelists:

Saul B. Gusberg, M.D., New York, New York
Associate Professor of Clinical Obstetrics and Gynecology, Columbia University College of Physicians and Surgeons; Associate Attending Obstetrician and Gynecologist, Sloane Hospital for Women, Vanderbilt Clinic and Francis Delafield Hospital of the Columbia-Presbyterian Medical Center

Robert B. Greenblatt, M.D., Augusta, Georgia
Professor of Endocrinology, Medical College of Georgia

Mitchell J. Nechtow, M.D., Chicago, Illinois
Attending Gynecologist, Cook County Hospital; Associate Professor of Obstetrics and Gynecology, Chicago Medical School; Professor of Gynecology, Cook County Graduate School; Chairman of Obstetrics and Gynecology, Norwegian American Hospital; Attending Gynecologist, Northwest Hospital.

Section on Urology

5:30 p.m. meeting

Chairman: A. Waite Bohne, M.D., Detroit
Secretary: Harry E. Lichtwardt, M.D., Birmingham

"REPAIR OF URETERAL INJURIES"

Clarence V. Hodges, M.D., Portland, Oregon

Professor of Surgery and Head of Division of Urology, University of Oregon Medical School

The urologist is often called upon to repair a ureteral injury under emergency situations in which a preconceived plan of action is imperative. Basic considerations call for preservation of renal tissue and utilization of the most physiologic channels possible. Consideration will be given to the various methods of ureteral repair with special emphasis on cross transplantation of ureters and autotransplants of the kidney.

Section on Internal Medicine

5:30 p.m. meeting and reception

Chairman: Hugh W. Henderson, M.D., Detroit
Secretary: Ralph R. Cooper, M.D., Grosse Pte.

"CORONARY HEART DISEASE AND THE REGULATION OF THE CORONARY CIRCULATION IN MAN"

Richard J. Bing, M.D., Detroit, Michigan

Professor of Medicine and Chairman, Department of Medicine, Wayne State University College of Medicine

The effect of experimental coronary occlusion in the dog will be discussed. Methods to measure coronary blood flow in patients will be described. Special emphasis will be placed on the description of the now acting coronary dilator drugs and on the emphasis of the features which would make an indeal coronary vasodilator drug.

Section on General Practice

5:30 p.m. meeting

Chairman: Winslow G. Fox, M.D., Ann Arbor
Secretary: Howard Robinson, M.D., Detroit

"OFFICE GYNECOLOGY"

Mitchell J. Nechtow, M.D., Chicago, Illinois

Attending Gynecologist, Cook County Hospital; Associate Professor of Obstetrics and Gynecology, Chicago Medical School; Professor of Gynecology, Cook County Graduate School; Chairman of Obstetrics and Gynecology, Norwegian American Hospital; Attending Gynecologist, Northwest Hospital.

Section on Surgery

5:30 p.m. meeting-reception-dinner

Chairman: Robert E. L. Berry, M.D., Ann Arbor
Secretary: Donald N. Sweeny, Jr., M.D., Detroit

"GUARANTEED PROCEDURES FOR INVITING MALPRACTICE SUITS"

Lester P. Dodd, LL.B., Detroit

Past President, State Bar of Michigan; Legal Counsel, Michigan State Medical Society

THURSDAY MORNING

September 28, 1961

Registration: 8:30 A.M., Civic Auditorium
Exhibits: 9:30 A.M., Civic Auditorium

Third Assembly

Black and Silver Ballroom, Civic Auditorium

Chairman: Robert E. L. Berry, M.D., Ann Arbor
Secretary: John W. Ditzler, M.D., Detroit

A.M.
9:00

"MODERN THEORY AND TREATMENT OF SHOCK"

Lawrence C. Hampson, M.D., West Montreal, Quebec, Canada

Assistant Surgeon, Montreal General Hospital; Lecturer, McGill University

Shock in the clinical context should be considered rather as a group of symptoms than a clinical entity. The primary consideration to be given when faced with a problem showing this clinical complex should be towards diagnosis as to the probable or possible cause of the syndrome. An attempt at differential diagnosis should be made, as in other clinical situations, so as to allow rational treatment of the disease process thought to be present.

In many instances prevention is seen to be very much more important than treatment and the application of current knowledge in this field in order to obviate subsequent clinical shock is essential.

The precise etiology of shock probably remains to be elucidated but experimental studies into the possible etiology of irreversible

shock have led to the implication of the liver, the kidneys, the mesenteric circulation, the heart itself, and bacteria and bacterial toxins.

In considering treatment the indications for blood, plasma, plasma substitutes, and electrolyte solutions will be discussed. The place of Vasopressor drugs, Sympatholytic drugs, Cortisone, and antibiotics will also be considered.

9:30

"BENIGN TUMORS OF THE BREAST"

CUSHMAN D. HAAGENSEN, M.D., New York, New York

Director of Surgery, Francis Delafield Hospital; Professor of Clinical Surgery, Columbia University, College of Physicians and Surgeons

10:00

INTERMISSION TO VIEW EXHIBITS

11:00

"VENOUS STASIS IN THE HUMAN LOWER EXTREMITIES"

ANGUS D. MCLACHLIN, M.D., London, Ontario, Canada

Member of Board of Regents, A.C.S.; President-Elect, Central Surgical Association; Professor and Head, Department of Surgery, University of Western Ontario

11:30

"USE AND ABUSE OF ANTIBIOTICS IN SURGICAL PATIENTS"

WM. ALTEMEIER, M.D., Cincinnati, Ohio

Christian R. Holmes Professor of Surgery and Chairman of the Department, University of Cincinnati; Director, Surgical Services, Cincinnati General Hospital; Surgeon-in-Chief, Children's and Holmes Hospitals

The widespread use of antibacterial agents in the prevention and treatment of surgical infections has exerted a profound effect on the practice and progress of surgery. The miracles that have followed the use of antibiotics have been widely publicized, and many surgeons have come to believe that the prevention and control of postoperative infections are no longer important problems. The basic principles of asepsis and antisepsis which permit the prevention of infection in elective surgical wounds have frequently been neglected, and blind reliance has often been placed on the effectiveness of antibiotics used prophylactically. This practice has brought into sharp focus the obvious limitations of chemotherapy in the prevention of infections and has emphasized the present problems in postoperative wound infections.

The indiscriminate use of prophylactic antibiotic drugs has been a major cause of the increase in bacterial resistance to these drugs, particularly in the case of the hemolytic *Staphylococcus aureus* and the various gram-negative bacteria, which are frequent causes of serious wound infections. The continued use of specific antibiotic agents has increased the incidence of strains resistant to those agents.

Hospitals have become reservoirs of antibiotic-resistant and virulent bacteria in patients, physicians, and other personnel who develop infections or become carriers of resistant strains. These resistant strains may infect new hospital patients, particularly those who are debilitated or unusually susceptible through cross-infection or superinfection. Thus, hospital-acquired infections may be particularly virulent and difficult to cure. The prevention of hospital-acquired infections, including postoperative wound infections, depends not upon the primary use of prophylactic antibiotic therapy, but upon established principles of isolation of infected individuals, aseptic and antiseptic techniques during and after operations, and good housecleaning. Unnecessary, inadequate, or ineffective antimicrobial administration contributes to the growth of antibiotic-resistant microorganisms.

Antibiotic therapy cannot be expected to prevent local infection in wounds of violence or in operative wounds if established surgical principles or important technical details have been ignored. A gradual relaxation of the "surgical conscience" is manifested by carelessness in many details of *aseptic technique* in the operating room and at the bedside, and by discontinuation of *isolation technique* for patients with virulent infections. The "exposure method" of treating wounds and burns appears to have aided in the emergence and dissemination of virulent and resistant bacteria in the hospital environment and thence into other wounds.

In the surgical treatment of wounds of violence, the intelligent prophylactic use of antibiotics is adjunctive therapy and of secondary importance to early and adequate operative removal of devitalized tissue and foreign material. The main benefit of this therapy lies in the attenuation, limitation, or control of infection from residual microorganisms in such wounds after debridement and operative repair, or in the localization of any infection developing within wounds in which surgical treatment was necessarily inadequate, delayed, or impossible.

Complications which may occur as a result of antibiotic therapy include: (1) toxic reactions in various organs; (2) allergic reactions, as seen with penicillin; (3) secondary or superimposed infections by bacteria developing resistance during chemotherapy with a change in bacterial flora of the wound or of the gastrointestinal tract; (4) masking of latent infection so that the usual signs and symptoms are suppressed; and (5) the development of fungus infections which may become particularly difficult to control.

It would appear that the answer to the question, "Will the present benefits of antibiotic treatment continue for the next ten years?" depends largely upon our ability to profit from our past experiences and to correct those practices which are limiting or eliminating the effectiveness of antibiotic agents. Active education of the physicians and general public in the dangers of indiscriminate use of antibiotics and more thoughtful consideration of the indications for these agents will do much to preserve their effectiveness for future patients and surgeons.

"There is no good without ill in the world, but everything is mixed in due proportion." "The evil that men do lives after them; the good is oft interred with their bones."

12:00

"THE ROLE OF THE ANESTHESIOLOGIST IN THE HOSPITAL AND IN THE COMMUNITY TODAY"

WM. S. DERRICK, M.D., Houston, Texas

Head of Section of Anesthesiology, the University of Texas; Professor of Anesthesiology, the University of Texas Postgraduate School of Medicine; Professor of Anesthesiology, the University of Texas Dental Branch

P.M.

12:30 END OF THIRD ASSEMBLY

THURSDAY AFTERNOON

September 28, 1961

Fourth Assembly

Black and Silver Ballroom, Civic Auditorium

Chairman: V. E. CORTOPASSI, M.D., Saginaw
Secretary: G. T. BRADLEY, M.D., Detroit

P.M.

2:00

"OCULAR MANIFESTATIONS OF LEUKEMIA"

BRADLEY R. STRAATSMA, M.D., Los Angeles, California

Associate Professor of Surgery; Chief, Division of Ophthalmology, University of California

Leukemia constitutes a unique and baffling disorder that often affects the eye. In its various forms, this disease is associated with a purposeless, uncontrolled, and probably neoplastic proliferation of the white blood cell forming tissues. On the basis of cell type and clinical course, leukemia may be classified as acute or chronic.

Acute leukemia is a fulminating disease associated with the abnormal accumulation of immature cells in the blood, hematopoetic organs, and other tissues. The eye participates in this process with resulting infiltration, anemic change, and hemorrhage that may be severe enough to destroy vision.

Chronic leukemia is essentially similar but more protracted. It is often responsible for uveal infiltration and less commonly associated with intraocular bleeding.

In the management of these diseases, the ophthalmologist can do much to insure prompt diagnosis and provide the supportive care that is essential when a malignant disease threatens vision.

2:30

"FACIAL NERVE INJURIES ASSOCIATED WITH HEAD INJURIES"

FRANK D. LATHROP, M.D., Boston, Massachusetts

Chief, Department of Otolaryngology, Lahey Clinic; Otolaryngologist, New England Baptist Hospital; Otologist, New England Deaconess Hospital

This discussion is concerned with the management of facial paralysis occurring as a result of fractures of the skull or lacerations of the face. Automobile and industrial accidents not infrequently result in fracture of the skull, laceration of the face, or a combination of both. In a moderate number of such injuries, the facial nerve is paralyzed. While the majority of patients exhibiting facial paralysis in association with a fracture of the skull will recover spontaneously from the paralysis, definitive surgical treatment is necessary in certain instances.

Deep lacerations of the face which produce facial paralysis may occur as a result of tearing or penetration of the soft tissues through forceful contact with metal, wood or glass as in automobile or industrial accidents, or they may be secondary to wounds produced by gun or knife. The facial paralysis in such instances may be partial or complete. Satisfactory recovery from the facial paralysis may occur spontaneously in some cases, but, in my experience, definitive surgical intervention is required in the majority of such paralyses in order to obtain maximum recovery.

3:00 INTERMISSION TO VIEW EXHIBITS

4:00

"A PRACTICAL APPROACH TO THE EVALUATION OF BONE TUMORS"

GWILYM S. LODWICK, M.D., Columbus, Missouri

Professor and Chairman, Department of Radiology, University of Missouri, Associate Dean of the School of Medicine, University of Missouri

The discussion is concerned with the application of data obtained in the comprehensive evaluation of a large series of bone neoplasms relating to the (1) diagnosis of bone tumors, (2) evaluation of behavior, and (3) appropriate treatment.

4:30

"TREATMENT OF DIVERTICULITIS"

HYRUM R. REICHMAN, M.D., Salt Lake City, Utah

Assistant Clinical Professor of Surgery, University of Utah College of Medicine; Chairman of Section of Gastroenterology-Proctology, American Medical Association; Past President, American Proctological Society; Past President, American Board of Colon and Rectal Surgery

5:00

"DISABLED FOR WHAT?"

LEMUEL C. MCGEE, M.D., Wilmington, Delaware
Medical Director, Hercules Powder Company; Attending Chief, Department of Medicine, Delaware Hospital; Visiting Professor of Internal Medicine, University of Pennsylvania School of Medicine

The growth of pension plans and the increase in the number of older workers create for the physician more requests for clinical examinations directed toward evaluation of medically determinable impairments. Such examinations and reports are needed in the administration of disability benefit programs of the Social Security Administration, of the Veterans Administration, of insurance companies, employers, and of other miscellaneous pension plans.

Factual information on the nature of the impairment of the applicant and its effect on his functional capacity is the obvious and unavoidable core of the medical report. Varying levels of permanent disability are found to be qualifying for differing pension plans. Furthermore, nonmedical factors of age, sex, length of service, education and skills, economic and social environment, and like influences enter into the acceptance or rejection of pension applications. Thus "rating" is ultimately an administrative decision resting on a multifaceted base.

With a given category of plans the standard of eligibility may be inability to perform any gainful work, inability to perform any job for the current employer, or inability to perform the regular job for the employer. Such variations can confuse both physicians and applicants unless due attention is given to (1) the varied requirements of the plans and (2) the fact-finding role of the medical examiner, who is not expected to determine whether disability exists under the terms of a plan.

In addition to these potential sources of misunderstanding, there are other problems for the applicant and the physician alike. A diagnosis, in itself, may give an incomplete clue to the degree of impairment and its effect on working ability. The evaluation of the impairment needs to be sufficiently complete and up to date as to serve its purpose of supporting a rating or determination. If an impairment can possibly be corrected by medical and surgical procedures, what degree of risk should be accepted by the impaired worker in undergoing the procedures?

The physician undertaking to rehabilitate a disabled worker quite often is thwarted by serious emotional disturbances in the patient which prevent ultimate recovery and satisfactory return to the job. The evaluation of the role of pain, of multiple minor impairments, and of the patient's psychologic adaptability leave considerable scope for the exercise of both medical and administrative judgment.

THURSDAY, SEPTEMBER 28, 1961

Program of Sections

Section on Occupational Medicine

5:30 p.m. meeting and reception

Chairman: WILLIAM JEND, JR., M.D., Detroit
Secretary: JOHN H. GANSCHOW, M.D., Detroit

"TRENDS IN HEALTH PROGRAMS FOR EMPLOYEES"

LEMUEL C. MCGEE, M.D., Wilmington, Delaware
Medical Director Hercules Powder Company, Attending Chief, Department of Medicine, Delaware Hospital; Visiting Professor of Internal Medicine, University of Pennsylvania School of Medicine

One hundred twenty-eight million Americans—72 per cent of the U. S. civilian population—had some form of health insurance through voluntary insuring organizations at the end of a recent year. Nearly 22 million were insured against major medical expense.

The pattern of growth, starting with hospital expense has been to coverage for surgery, for regular medical expense, for loss of income, and for major medical expense. Health insurance premiums received by all types of voluntary insuring organizations in 1959 reached a total of 6.7 billion. Health insurance benefits paid to insured persons reached 5.2 billion in the same year. The insuring organizations comprised 737 insurance companies, 78 Blue Cross plans, 68 Blue Shield plans, and over 300 independent plans.

Medical care items in the Consumer's Price Index (1947-49 base of 100), show an uneven rise during the past decade. Hospital room rates increased 109 per cent; general practitioner's fees increased 44 per cent; dentists' services, 35 per cent; surgeons' fees, 26 per cent; prescriptions and drugs rose 23 per cent.

Health programs are increasingly costly. Multiplant industries seek a more equitable homogeneity in the prepaid insurance coverage for employes. Can all of the cost in medical care be justified? What acceptable cost control measures can be used without jeopardizing quality of medical care?

Trends in the development of health programs are influenced by numerous factors, such as, inflation, acceptance of individual responsibility by the insured, the insurer and the purveyors of medical care, the utilization of rehabilitation facilities, the application of principles of preventive medicine, and growth in our body of medical knowledge and skill.

Section on Otolaryngology

5:30 p.m. reception-dinner-meeting

Chairman: V. E. CORTOPASSI, M.D., Saginaw
Secretary: D. S. BOLSTAD, M.D., Detroit

"PAROTID GLAND TUMORS"

FRANK D. LATHROP, M.D., Boston, Massachusetts
Chief, Department of Otolaryngology, Lahey Clinic; Otolaryngologist, New England Baptist Hospital; Otologist, New England Deaconess Hospital

Tumors of the parotid gland are not uncommon. The majority of the tumors in this location are of salivary gland origin. Other pathologic conditions, however, such as lymphoma, metastatic malignancy, Warthin's tumor, Mikulicz's disease and chronic inflammation, may affect the parotid gland and must be differentiated from those of salivary gland origin. Most of the tumors of salivary gland origin arising in the parotid gland are benign. Malignant tumors do occur, however, and are much more difficult to eradicate than are those considered to be benign.

The treatment of parotid neoplasms of salivary gland origin is primarily surgical. X-ray irradiation may be indicated in selected cases when combined with surgical intervention but, in my opinion, is never indicated as the sole method of treatment. There is no doubt that fear on the part of the surgeon that facial paralysis may follow excision of a parotid tumor is probably the greatest deterrent to the adequate removal of such a neoplasm. If the surgeon is familiar with the anatomy of this area and exercises due care, adequate surgical removal of the tumor may be accomplished without producing permanent paralysis of the face unless the tumor actually invades the facial nerve. If at operation the facial nerve is involved by the tumor, the nerve must be sacrificed in order to permit adequate removal of the neoplasm. Even then the patient need not be left with permanent complete paralysis of the face for suitable reparative measures to the facial nerve will result in satisfactory relief from the facial palsy.

Section on Gastroenterology and Proctology

5:30 p.m. reception-dinner-meeting

Chairman: G. T. Bradley, M.D., Detroit
Secretary: L. C. Alexander, M.D., Detroit

"THE STATUS OF THE ADENOMA IN CANCER OF THE RECTUM AND COLON"

Hyrum R. Reichman, M.D., Salt Lake City, Utah

Assistant Clinical Professor of Surgery, University of Utah College of Medicine; Chairman of Section of Gastroenterology-Proctology, American Medical Association; Past President, American Proctological Society; Past President, American Board of Colon and Rectal Surgery

Section on Radiology and Michigan State Radiological Society

5:30 p.m. meeting

Chairman: Donald A. Koch, M.D., Port Huron

"COMPUTER DIAGNOSIS IN RADIOLOGY"

Gwilym S. Lodwick, M.D., Columbus, Missouri

Chairman, Department of Radiology, University of Missouri

This discussion will relate to the experience of the author in developing the steps leading from conversion or roentgenographic data through numerical sequences, to the diagnosis and behavior through the application of a computer. The future of the program will be discussed, and other similar efforts will be reviewed.

Section on Anesthesiology and Michigan Society of Anesthesiologists

5:30 p.m. reception-dinner-meeting

Chairman: John W. Ditzler, M.D., Detroit

"ANESTHESIOLOGY AND THE TEXAS MEDICAL CENTER IN HOUSTON"

Wm. S. Derrick, M.D., Houston, Texas

Head of Section of Anesthesiology, University of Texas; Professor of Anesthesiology, University of Texas Postgraduate School of Medicine; Professor of Anesthesiology, University of Texas Dental Branch

Joint Meeting of Section on Nervous and Mental Diseases and Michigan District Branch of American Psychiatric Association and Michigan Society of Neurology and Psychiatry

5:30 p.m. reception-dinner-meeting

Chairman: R. A. Jaarsma, M.D., Flint
Secretary: G. H. Reye, M.D., Flint

"PSYCHIC ENERGY"

Ivan C. Berlien, M.D., Miami, Florida

Associate Professor of Psychiatry and Director of Research, Department of Psychiatry, University of Miami School of Medicine

Section on Ophthalmology

5:30 p.m. meeting

Chairman: Paul Van Portfliet, M.D., Grand Rapids
Secretary: Robert J. Crossen, M.D., Detroit

"MELANOTIC EPIBULBAR TUMORS"

Bradley R. Straatsma, M.D., Los Angeles, California

Associate Professor of Surgery; Chief, Ophthalmology, University of California Medical Center; Consultant and Chief of Ophthalmology, Harbor General Hospital, Los Angeles and Veterans Administration Hospitals; Consultant to Surgeon General, USPHS

Melanotic tumors of the eyelid and conjunctiva are of the greatest significance because of their frequent occurrence and the importance of accurate diagnosis. These lesions develop from two major cell groups that are capable of forming melanin in the skin and mucous membranes. One of these is located at the junction of the epithelium and underlying tissue; the other group is located in the connective under the epithelium.

Melanin forming cells at the junction of epithelium and underlying tissue are responsible for racial skin pigmentation, account for tanning after active radiation, and are seen in the conjunctiva as striated pigment spots near the limbus. Tumor formation from these cells accounts for the common nevus in its junctival, compound, and for the condition of precancerous and cancerous melanosis dermal forms. Any nevus with a junctival component and any lesion of precancerous melanosis may undergo alteration and become a malignant melanoma. Melanin producing cells in the subepithelial tissue account for the Mongolian spot, the extrasacral spot, and the pigment about emmissary vessels of the eye. In excess, these cells are responsible for melanosis oculi or nevus of Ota, and they may proliferate to form a blue nevus or, rarely, a malignant melanoma.

These pigmented lesions require the utmost care in clinical study and histological diagnosis to insure appropriate management.

THURSDAY EVENING

September 28, 1961

State Society Night

STATE SOCIETY DINNER DANCE

Ballroom, Pantlind Hotel, Grand Rapids

7:00 p.m. Reception-Dinner-Speaker

THE ANDREW P. BIDDLE, M.D., LECTURE "SO YOU WANT TO GO INTO BUSINESS"

Homer H. Stryker, M.D., Kalamazoo, Michigan

Orthopedic Surgeon; Chief of Orthopedic Service, Borgess Hospital

Floor Show and Dancing

All MSMS members and their ladies are invited to the "State Society Dinner Dance." This new event combines the former Officers Night Dinner Dance and the State Society Night "gridiron."

HOTEL RESERVATIONS
for the
96th ANNUAL SESSION
MSMS
should be made
NOW

Write Jack Ament, Secretary
MSMS Housing Committee
Pantlind Hotel,
Grand Rapids, Michigan

FRIDAY MORNING

September 29, 1961

Registration: 8:30 a.m., Civic Auditorium

Exhibits: 9:30 a.m., Civic Auditorium

Fifth Assembly

Black and Silver Ballroom, Civic Auditorium

Chairman: R. A. Jaarsma, M.D., Flint
Secretary: S. T. Harris, M.D., Ypsilanti

A.M.
9:00

Panel on "PSYCHIATRIC INTERVIEW TECHNIQUES WITH SPECIAL REFERENCE TO GENERAL PRACTICE"

Moderator:

Winslow G. Fox, M.D., Ann Arbor, Michigan

Panelists:

Ivan C. Berlien, M.D., Miami, Florida
Associate Professor of Psychiatry and Director of Research, Department of Psychiatry, University of Miami School of Medicine

Theodore A. Watters, M.D., New Orleans, Louisiana
Clinical Professor of Psychiatry, Louisiana State University School of Medicine: Consultant in Psychiatry, The Texas County and Illinois Central Railroad

10:00 INTERMISSION TO VIEW EXHIBITS

11:00

"CONTINUATION OF PANEL ON PSYCHIATRIC INTERVIEW TECHNIQUES WITH SPECIAL REFERENCE TO GENERAL PRACTICE"

11:30

Panel on "EXAMINATION AND SPECIAL MEDICAL PROBLEMS OF THE ADOLESCENT"

Moderator:

James L. Wilson, M.D., Ann Arbor
Professor of Pediatrics and Communicable Diseases; Chairman, Department of Pediatrics and Communicable Diseases, University of Michigan Medical Center

Panelists:

J. Roswell Gallagher, M.D., Boston, Massachusetts
Chief, The Adolescent Unit, Children's Hospital Medical Center; Lecturer on Pediatrics, Harvard Medical School

Carl P. Huber, M.D., Indianapolis, Indiana
Professor and Chairman, Department of Obstetrics and Gynecology, Indiana University School of Medicine; Chief of Staff, Wm. H. Coleman Hospital for Women, Indiana University Medical Center

P.M.
12:30

END OF FIFTH ASSEMBLY

12:30

FINAL INTERMISSION TO VIEW EXHIBITS

FRIDAY, SEPTEMBER 29, 1961

Program of Sections

Joint Meeting of Sections on Radiology, Pathology and Michigan Pathological Society

2:00-5:00 P.M.

Chairman: Donald A. Koch, M.D., Port Huron
Secretary: James G. Wolter, M.D., Detroit

BONE TUMOR SEMINAR

Moderator:

Ernest E. Aegerter, M.D., Philadelphia, Pennsylvania
Director of Pathology, Temple University School of Medicine and Hospital

Participant:

Gwilym S. Lodwick, M.D., Columbus, Missouri

Section on Pediatrics and Michigan Branch, American Academy of Pediatrics

6:00 p.m., Reception—Dinner-Meeting

Chairman: John L. Doyle, M.D., Grand Rapids
Secretary: Scott T. Harris, M.D., Ypsilanti

"THE ADOLESCENT AND OUR SOCIETY"

J. Roswell Gallagher, M.D., Boston, Massachusetts
Chief, The Adolescent Unit, Children's Hospital Medical Center; Lecturer on Pediatrics, Harvard Medical School

A discussion of the general nature of the adolescent, the problems which his physiological and psychological growth processes present to him, and the influence which genetic and environmental factors have upon his development, together with some comments about the prevention of their problems.

THAT IS

THE MSMS ANNUAL SESSION!

Annual Committee Reports

ANNUAL REPORT OF MENTAL HEALTH COMMITTEE—1960-1961

Summary of Recommendations:

that work continue upon the understanding of critical problems during community disaster;
that this Committee cooperate to the fullest extent of its abilities with the MSMS National Defense Committee;
that MSMS education resources be available for our AMA Psychiatric Congress, scheduled for the fall of 1961;
that the Mental Health Committee chairman, or his designated delegate, attend the AMA Annual Conference of Mental Health Representatives of State Medical Associations;
that our MSMS Legislative Committee continue active support of the Interstate Compact on Mental Health;
that educational work on the medical, including personal, problems of patient care in nursing homes be continued;
that there be an MSMS Committee on alcoholism and narcotics addiction;
that continuing orientation with regard to hypnosis, particularly the grave responsibility connected with it, be provided for the undergraduate medical student and for the physician in practice;
that health opportunity for the mentally retarded child be a subject of intensive application;
that every M.D. contribute to the success of the admirable project HOPE;
that representatives of our MSMS Woman's Auxiliary be invited to attend regular meetings of the MSMS Mental Health Committee;
that a Mental Health Number of our MSMS Journal be encouraged;
that The Council affirm its stand that the practice of psychotherapy is the practice of medicine;
that Mental Health bills introduced into the State Legislature be carefully studied.

During the year ending June, 1961, this Committee held four general meetings. Beloved Osler considered the magic word in medicine to be: *Work.* A magic word which may be added is: *Education.* Illness, accident, and every kind of health ordeal, are most costly forms of education. Education to health is most economic. The Committee has systematically aimed at advancing the practicality of psychiatry for its use by every M.D. The Michigan Clinical Institute Panel on *Care of the Older Person in Nursing Homes,* joint project with the MSMS Geriatrics Committee, proved helpful. Doctor Raymond W. Waggoner and his subcommittee prepared an excellent Mental Health Number for our MSMS Journal (September, 1961). The Chairman thanks every member of his committee for the finest kind of collaboration and inspiration.

John M. Dorsey, M.D., *Chairman*
Z. S. Bohn, M.D., *Vice Chairman*
C. P. Barker, M.D.
H. W. Bird, M.D.
P. N. Brown, M.D.
R. O. Creager, M.D.
T. J. Heldt, M.D.
L. N. Hershey, M.D.
A. H. Hirschfeld, M.D.
W. T. Hyslop, M.D.
R. F. Kernkamp, M.D.
I. A. LaCore, M.D.
J. J. Marra, M.D.
C. J. Mumby, M.D.
W. H. Obenauf, M.D.
D. D. Salon, M.D.
W. R. Slenger, M.D.
R. W. Waggoner, M.D.
H. B. Zemmer, M.D., *Advisor*

ANNUAL REPORT OF RHEUMATIC FEVER CONTROL COMMITTEE—1960-1961

The Rheumatic Fever Control Committee recommends that, pending the outcome of a survey now in progress, its activity continue along educational lines directed to the medical profession.

Although Rheumatic Fever Diagnostic Centers continue to become less active, and to become inactive in at least one case, the public (*Time,* April 28, 1961) continues to be made aware of the fact that rheumatic fever is a major problem. Members of the Rheumatic Fever Control Committee are of the collective opinion that diagnosis and treatment of streptococcal infections and prophylaxis of recurrent rheumatic episodes is still not at an optimal level. A program is now under way to

1. Ascertain the status of rheumatic fever in selected Michigan hospitals providing arrangements can be made by the Michigan Crippled Children Commission to obtain funds for a study to be made of the records collected by the Commission on Professional and Hospital Activities, Ann Arbor.

2. Ascertain M.D. interest by re-issuing the Desk Reference Cards to those members of MSMS who request them in response to an initial mailing of one of the critical (Number 2, Prevention and Prophylaxis) cards.

A subcommittee working with Ann Arbor and Detroit men will revise this card during the summer, and at its next meeting each member of the Committee will submit a revision for one of the remaining cards, so that the entire series will again be in line with current thinking. The complete series of 20 cards provides a concise review of rheumatic fever.

It has been recommended that the name and scope of this Committee be changed to "Cardiac

Disease Control"; this change will come up at the next House of Delegates meeting.

The Committee notes with regret the untimely death on February 7, 1961, of Dr. Earle Schumacher of Grand Rapids at the age of thirty-five.

The committee wishes to thank the staff of MSMS for its assistance in the Committee's work.

The only meeting of the Committee was on April 26, 1961.

Robert E. Fisher, M.D., *Chairman*
F. J. Chapin, M.D., *Vice Chairman*
E. W. Adams, M.D.
R. R. Barber, M.D.
J. G. Bielawski, M.D.
Carleton Dean, M.D.
A. E. Gamon, II, M.D.
S. T. Harris, M.D.
T. B. Hill, M.D.
C. L. Hoogerland, M.D.
J. D. Littig, M.D.
N. L. Matthews, M.D.
W. B. Prothro, M.D.
J. S. Rozan, M.D.
D. S. Smith, M.D.
B. J. Sweeney, M.D.
R. D. Tupper, M.D.
H. R. Weisheit, M.D.
Mr. Abraham Brickner, *Advisor*
Mr. James Gerity, Jr., *Advisor*

ANNUAL REPORT OF MATERNAL HEALTH COMMITTEE—1960-1961

October 1960 meeting at the Statler Hotel in Detroit. The subcommittees on expectant parent education, medical liaison, maternal mortality review and perinatal mortality were all reappointed.

We laid the plans for a meeting in Flint for January, Doctor Bald to direct the planning specifically.

There was some discussion, no action, on a possible plan to stimulate a better family relations program in schools.

In January, 1961, the Flint meeting was a huge success. The State Society had invited county medical society maternal health chairmen but this representation was disappointing. We were introduced to the Clara Elizabeth Fund activities under the organization of Dave Treat. He did a great job as did Doctor Bald. In the evening, George W. Anderson, M.D., of Boston, provided by the Clara Elizabeth Fund and the State Health Department, gave an excellent review of the pathology involved and the general subject of perinatal mortality. Doctor Cipparone from Lansing's St. Lawrence Hospital pathology staff likewise discussed the subject. Doctor Trescott of our Committee and Doctor Cipparone have been instrumental in establishing one of the State's best studies of infant deaths.

On May 11, 1961, a meeting was held at the Lansing Country Club. The wives were invited at the individual doctor's expense. The year's work was summarized but no new activities were planned until the Chairman for next year is appointed. John M. Sheldon, M.D., of the University of Michigan Department of Postgraduate Medicine, presented a review of the Postgraduate activities of the University.

The Maternal Health Committee will participate as usual in the Walden Woods program for expectant parent teachers. This activity is a yearly project of the Health Department.

F. A. Jones, Jr., M.D., *Chairman*
H. A. Ott, M.D., *Vice Chairman*
F. W. Bald, M.D.
C. A. Behney, M.D.
C. M. Bell, M.D.
H. R. Brukardt, M.D.
Goldie B. Corneliuson, M.D.
C. E. Darling, M.D.
A. L. Foley, M.D.
E. C. Galsterer, M.D.
W. F. Goins, M.D.
J. E. Harryman, M.D.
Wm. W. Jack, M.D.
Wm. W. Kitti, M.D.
W. C. Lambert, M.D.
H. W. Longyear, M.D.
A. G. McQuaig, M.D.
N. F. Miller, M.D.
H. R. Mooi, M.D.
J. W. Peelen, M.D.
A. C. Rutzen, M.D.
H. W. Sill, M.D.
C. S. Stevenson, M.D.
P. E. Sutton, M.D.
M. Suzuki, M.D.
D. W. Thorup, M.D.
J. H. Tisdel, M.D.
C. E. Toshach, M.D.
R. F. Trescott, M.D.
H. R. Williams, M.D.
Mary Lou Byrd, M.D., *Advisor*

ANNUAL REPORT OF ADVISORY COMMITTEE TO WOMAN'S AUXILIARY—1960-1961

The Chairman of the Advisory Committee to the Woman's Auxiliary has had first hand contact with them this year and has realized what a tremendous job they are doing. We have not been called upon to assist them specifically in any capacity this past year because their committees seem to function very smoothly and much has been accomplished.

Their contribution to AMEF this year will be close to $9,000.00 . . . their health careers chairmen from the county level have raised close to $6,000.00 . . . their legislative activities have resulted in thousands of letters written to Congress protesting Forand type legislation. At this time they are working on Operation "Coffee Cup" . . . one hundred records of "Ronald Reagan speaks out against Socialized Medicine" are being distributed throughout the State. This project was the result of the emergency meeting of the House of Delegates in Lansing April 16, 1961.

The Auxiliary has been pleased to cooperate with the Advisory Committee of the State Society and expresses its thanks to all the staff of the Michigan State Medical Society offices in Lansing, and especially to Messrs. Bill Burns, Hugh Brenneman, and Warren Tryloff.

There was no formal meeting with the Auxiliary officers since Convention in Detroit last September, however, being the husband of the President, I feel that their activities were well observed because it was my privilege to be in contact with most of the officers these past twelve months and also the year before that.

There is still a gap in the membership of the Auxiliary . . . I strongly recommend that the county medical societies extend greater cooperation to the Auxiliary. Approximately half of the doctors' wives throughout the State belong and unless we encourage our wives to become auxiliary members, we are missing out on a very strong potential of the very finest public relations media.

It is my recommendation that the Advisory Committee and members of the Michigan State Medical Society staff meet with the officers and finance committee of the Woman's Auxiliary at least once a year to become better acquainted with their projects, activities and finances.

Paul Ivkovich, M.D., *Chairman*
E. H. Meisel, Jr., M.D.
R. E. Reagan, M.D.

ANNUAL REPORT OF ADVISORY COMMITTEE TO THE MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY—1960-1961

The Advisory Committee to the MSMAS had one formal meeting on March 9, 1961 with the Executive Committee of MSMAS. Several informal meetings were held between the Chairman of the Advisory Committee and the officers of the Medical Assistants Society.

The current activities of this Committee are:

1. The adoption of the University of Michigan teaching syllabi to the junior colleges and other local institutions for future training of medical assistants.

2. Formal recognition of the medical assistants that have completed this three-year in-service program. MSMS has agreed to register in its offices the ladies that have completed the program and the Medical Assistants Society will recognize each person who has completed the full course of study with a certificate. The extension service of the University of Michigan has presented certificates already to those who have completed the courses in the pilot project. The organization at the present time is investigating its financial and membership potential so that it can consider opening a fulltime office for their society. They may need some temporary support from the doctors of the State for the first year or two until they can place this office on its feet.

3. An office could provide an even better State Medical Assistants Publication including advertising, classified ads particularly those for medical assistants, keep the membership records and the dues collected, promote the organization on a full-time basis, et cetera.

This organization has won the National Award for the best publication for two years in succession.

Future activities include a National convention which will be held in Detroit following the MSMS meeting in September of 1962.

The American Association of Medical Assistants has grown from nothing to over 9,000 members in five years. The Michigan organization has about 1,000 members and is one of the strongest in the National organization. They have received support from the AMA and from MSMS and the MSMAS Advisory Committee recommends that the doctors of Michigan continue to support this organization and that doctors themselves render any additional encouragement that they can.

G. E. Millard, M.D., *Chairman*
R. E. Carlson, M.D.
D. B. Johnson, M.D.
A. S. Narotzky, M.D.
J. W. Rice, M.D.
T. J. Trapasso, M.D.

ANNUAL REPORT OF THE ETHICS COMMITTEE—1960-1961

As of this date, May 22, 1961, there have been no ethical problems submitted to this committee. Every member was contacted by phone two weeks before the deadline and nobody has had a complaint from anyone.

It could be that the great issue of the King-Anderson Bill, H.R. 4222, and its implications has made all other problems seem insignificant and totally unworthy of any attention.

We have heard here and there of some minor infractions but none apparently grew to any proportions and were buried in the present threat of socialized medicine.

Whatever the explanation it seems to show that possible violators have seen fit to behave or else the errors of commission have been intentionally brushed aside for the present more vital issues.

The budget of this Committee will have been used for more important things and to whatever is the cause of the complete lack of irritating unethical problems worth spending time on we are grateful. We believe this establishes a record since the State Society formed an Ethics Committee.

If any reader of this report is especially interested in ethics, the AMA has recently published a fine manual: "Opinions and Reports (of the AMA) Judicial Council, abstracted and annotated to the Principles of Medical Ethics: December, 1960." Copies may be obtained free by writing to the AMA, 535 North Dearborn St., Chicago 10, Illinois.

H. W. Porter, M.D., *Chairman*
W. L. Harrigan, M.D., *Vice Chairman*
F. M. Doyle, M.D.
F. H. Lindenfeld, M.D.
J. D. Miller, M.D.
A. Hazen Price, M.D.
P. K. Stevens, M.D.

ANNUAL REPORT OF COMMITTEE ON STUDY OF PREVENTION OF HIGHWAY ACCIDENTS—1960-1961

One meeting of the Committee was held in the fall and discussion was held with the Executive Secretary of the Michigan Safety Commission and with the Chief of the Driver Improvement Program of the Michigan Department of State. Mutual problems were discussed in the field of driver licensing. It was moved by the Committee that the MSMS send another notice to the county medical societies urging them to appoint county medical appeal boards for the medical evaluation of drivers whose licenses have been suspended, where the Department of State feels that a physical condition detrimental to driving may exist. The formation of such boards was recommended by the Committee and passed on favorably by The Council in 1959, but few county societies have appointed them as yet. Action on these minutes at the time of preparing this report still has not been made by The Council due to illness of Legal Counsel and other pressing matters. For this reason, a second meeting of the Committee for the spring was not called.

During the year, the members of the Committee were active in many local traffic safety endeavors. The Chairman participated in the programs of the State Safety Conference in Lansing and of the State Health Conference in Flint, and collaborated in the preparation of the letters sent to the motor car companies from the State Society as a result of the resolution of the House of Delegates last year. He also participated in the traffic safety program of the Bay-Arenac-Iosco County Medical Society in the winter.

J. R. Rodger, M.D., *Chairman*
G. H. Agate, M.D.
R. T. Blackhurst, M.D.
H. E. DePree, M.D.
C. M. Hansen, M.D.
E. H. Heneveld, M.D.
W. N. Herbert, M.D.
A. Z. Howard, M.D.
S. N. Lyttle, M.D.
S. E. Miller, M.D.
W. D. Peterson, M.D.
H. J. Meier, M.D., *Advisor*

ANNUAL REPORT OF THE PUBLIC HEALTH COMMITTEE—1960-1961

The Public Health Committee constitutes a change in name from that of the Preventive Medicine Committee which it replaced.

It is the opinion of the members of this committee that the change in name would indicate that a somewhat enlarged concept of the purpose of the committee to the extent that not only the activities on disease prevention should be continued and extended but continued emphasis on health promotion of the people of Michigan must be provided.

By such a committee policy, the committee can assume its role of stimulating activities in the MSMS Presidential Program and also serve as the coordinator of the various committee activities, the chairmen of which make up the membership of the Public Health Committee.

It is contemplated that the Public Health Committee should serve not only as a coordinating agency of the various activities of the various committees above referenced but should also meet shortly after the Annual Meeting of the MSMS in order to consider overall planning for the coming year of committee activities.

One meeting was held by the Public Health Committee this year at which time the members reported on the activities of their specific committees. Minutes of all committee meetings have been studied by the Chairman of the Public Health Committee and reports show an exceptionally significant and productive work.

O. D. Stryker, M.D., *Chairman*
B. E. Brush, M.D.
J. M. Dorsey, M.D.
R. E. Fisher, M.D.
A. E. Heustis, M.D.
E. A. Irvin, M.D.
F. A. Jones, Jr., M.D.
Wm. M. LeFevre, M.D.
H. M. Nelson, M.D.
A. Hazen Price, M.D.
R. L. Rapport, M.D.
Benjamin Schwimmer, M.D.
J. M. Sheldon, M.D.
H. A. Towsley, M.D.
R. H. Trimby, M.D.
W. S. Reveno, M.D.

ANNUAL REPORT OF TUBERCULOSIS CONTROL COMMITTEE—1960-1961

The Tuberculosis Control Committee met on March 1, 1961.

1. The Committee restated its firm belief that tuberculosis continues to be a serious public health problem, and that this is no time to discontinue intensive efforts directed towards case finding and adequate treatment.

2. In conjunction with Michigan Tuberculosis Association a joint Speakers Bureau has been established which is available to speak to both professional and lay groups.

3. The Committee notes a lack of specific information on the subject of tuberculosis detection, treatment and control on the part of practicing physicians, and recommends to The Council that the subject of tuberculosis should be incorporated in the appropriate section of the Michigan Clinical Institute.

4. The Committee was represented at two meetings of the Michigan Tuberculosis Coordinating Council, a new organization designed to bring together the many groups concerned with tuberculosis and its control.

5. The Committee concurred in the recommendations of the Michigan Tuberculosis Coordinating Council not to consider compulsory skin testing at this time and approved the recommendations

of Michigan Tuberculosis Coordinating Council in regard to the testing of school personnel.

6. The Committee noted that the organization of the State Health Department is such that decisions of the Commissioner of Health are unilateral, and he is therefore unable to benefit from the advice of MSMS. Therefore, the Committee recommends to The Council of MSMS that it direct its Legislative Committee to investigate the advisability of reorganization of the Department of Health to establish a *Board of Health* so empowered as to provide for checks and balances on the decisions of the Commissioner.

R. L. Rapport, M.D., *Chairman*
Abraham Becker, M.D.
P. T. Chapman, M.D.
M. B. Conover, M.D.
W. N. Davey, M.D.
J. L. Egle, M.D.
J. L. Isbister, M.D.
A. H. Kempter, M.D.
E. J. Klopp, M.D.
C. P. Mehas, M.D.
G. H. Phillips, M.D.
R. A. Rasmussen, M.D.
C. J. Stringer, M.D.
J. W. Towey, M.D.
Jack Foy Wu, M.D.
Stewart Yntema, M.D.

ANNUAL REPORT OF IODIZED SALT COMMITTEE—1960-1961

Plans for a film on the importance of using iodized salt are being completed and we hope to have this educational movie available soon for distribution to several Michigan groups.

An up-to-date scientific exhibit is planned for the MSMS Annual Meeting in Grand Rapids in 1961. Doctor Beierwaltes attended the 4th International Goiter Conference in London, England, and gave us a summary of the material presented there. Doctor Altland presented the results of surveys on the sale of plain vs. iodized salt in four Michigan counties (Houghton; Macomb; Midland; Wexford), and again brought out the need for continuing public education.

One meeting was held during the year at the home of Harry M. Towsley, M.D. at Ann Arbor. Our chief project is to finish the movie and give it nation-wide distribution to Parent-Teacher Association, school groups, grange meetings, etc.

B. E. Brush, M.D., *Chairman*
H. A. Towsley, M.D., *Vice Chairman*
J. K. Altland, M.D.
Wm. H. Beierwaltes, M.D.
J. R. Carney, M.D.
R. L. Waggoner, M.D.

ANNUAL REPORT OF OCCUPATIONAL MEDICINE COMMITTEE—1960-1961

1. Two Committee meetings were held—March 10 and May 12, 1961.

2. Committee requested that the name of the Committee be changed to, "Committee on Occupational Health." This change will be consistent with the name of the Council on Occupational Health of the American Medical Association.

3. A recommendation was made to The Council of the MSMS that a program to improve health maintenance of employees in industry be formulated by the Committee and that action, subject to approval of The Council, be taken which would accomplish objectives of this program.

4. A joint meeting is planned with the legal representative of the MSMS and representatives of the Michigan Association of Professions for the discussion of the problem of workmen's compensation in Michigan.

5. The Committee is in the process of developing the scope and objectives of this Committee.

E. A. Irvin, M.D., *Chairman*
S. E. Andrews, M.D.
J. G. Beall, M.D.
T. I. Boileau, M.D.
E. B. Cudney, M.D.
Edwin De Jongh, M.D.
J. H. Ganschow, M.D.
F. E. Kolb, M.D.
D. F. Kudner, M.D.
C. P. McCord, M.D.
G. P. Moore, M.D.
R. D. Mudd, M.D.
P. J. Oschner, M.D.
O. J. Preston, M.D.
D. M. Richmond, M.D.
N. W. Scholle, M.D.
M. W. Shellman, M.D.
S. D. Steiner, M.D.
W. E. VanGelder, M.D.
A. H. Whittaker, M.D.
J. K. Wright, M.D.

ANNUAL REPORT OF VENEREAL DISEASE CONTROL COMMITTEE—1960-1961

One meeting was held by this Committee during the year 1960-61 and several matters of importance were discussed.

The following recommendations were made:

1. That the Michigan Department of Health laboratories continue the use of the VDRL in lieu of the Kahn as the standard reagin test.

2. That the records of the Michigan Rapid Treatment Center be preserved for study at the appropriate time when funds are available.

3. That there was a need for physician education in veneral disease.

4. That the United States Public Health Service be encouraged to continue mass screening surveys in high incidence areas.

5. That the routine admission STS be continued by hospitals.

Dr. John A. Cowan reported an increase of primary and secondary syphilis in Michigan in 1959-1960 over 1958-1959. The figures were 146 for the former, and 79 for the latter. Increases had taken place in Berrien, Gratiot, Isabella, Genesee, and Wayne Counties. Every other category of syphilis decreased during this period. He reported that the national figures show an increase of 52% in primary and secondary syphilis

in 1960 over 1959. He advised the Committee that of 22 Health Department Veneral Disease Clinics in Michigan, only Calhoun County, Kalamazoo County, Flint City, Detroit City, and Wayne County have darkfield equipment. He reported that 50% of the private laboratories in Michigan report positive serological tests for syphilis reported by private physicians.

Doctor Schwimmer stressed the importance of the physical examination as a major part of the diagnosis of syphilis, so that the physician need not rely entirely on the laboratory for diagnosis. Physical examination also aids in better interpretation of laboratory findings. He also expressed the opinion that an important factor in the local, state, and national rise in infectious syphilis is the decreasing use of penicillin. The increasing danger of anaphylaxis has resulted in fewer persons being cured of syphilis or rendered non-infectious inadvertently if they are treated with penicillin for some other condition.

A letter was sent to Doctor Loren W. Shaffer in Florida, inviting him to attend future meetings. The Chairman commended the attendance of Doctor R. S. Breakey and invited him to attend future meetings.

Benjamin Schwimmer, M.D., *Chairman*
M. W. Algorn, M.D.
J. A. Cowan, M.D.
A. C. Curtis, M.D.
R. H. Grekin, M.D.
Ruth Herrick, M.D.
P. J. Hettle, M.D.
H. L. Keim, M.D.
R. I. Lurie, M.D.
H. C. Tellman, M.D.
Kornelius Van Goor, M.D.
R. S. Breakey, M.D., *Advisor*
L. W. Shaffer, M.D., *Advisor*

ANNUAL REPORT OF GERIATRICS COMMITTEE—1960-1961

The Geriatrics Committee is preparing again an issue of the Michigan State Medical Society Journal—October, 1961—to be devoted to some of the community projects for the aging throughout our state.

A complete evaluation is under way of the pilot project recently conducted in Grand Rapids for the examination of individuals applying for old age assistance. It is hoped it will be applicable in other areas.

A subcommittee is studying ways and means of caring for older people who are mentally ill and could be cared for in facilities other than state hospitals. The possibility of using selected nursing homes for this type of care is being considered.

Another subcommittee is studying a new project for housing the elderly in conjunction with Wayne University Medical School. It is hoped this could be used as a research effort to study all the factors influencing the lives of older people.

Our Committee has met three times during the year—once each in Detroit, Lansing, and Ann Arbor.

The May, 1960, issue of the Michigan State Medical Society Journal was devoted to the well older person and reprints have been widely distributed throughout the country to all state medical societies and to many of the delegates to the White House Conference on Aging. This was made possible through a grant from the McGregor Fund.

Three members of our Committee were delegates to the White House Conference on Aging and reported in detail to the Committee of all that happened at this very important meeting.

A public meeting was held in Detroit during the Michigan Clinical Institute as a combined effort of the Mental Health and Geriatrics Committees. The psychologic and psychiatric aspects of patient care in nursing homes was the subject under discussion. Dr. Jack Weinberg of Chicago was the principal speaker, and his coming was made possible by the McGregor Fund.

Three of our members have been active with the Joint Council to Improve the Health Care of the Aged, meeting with the other associations' members at regular intervals. Recently a section of the Michigan Health Council's annual meeting was devoted to this subject.

While the State Society is not a co-sponsor of the University of Michigan Gerontology Conference this year, we hope to have a large representation at the meeting. The Political Aspects of Aging is the conference theme, and medicine's viewpoint must be presented.

A. Hazen Price, M.D., *Chairman*
F. C. Swartz, M.D., *Vice Chairman*
H. B. Bennett, M.D.
J. R. Brink, M.D.
S. E. Chapin, M.D.
J. W. Clay, M.D.
E. F. Crippen, M.D.
R. L. Fitts, M.D.
J. V. Fopeano, M.D.
P. C. Gittins, M.D.
A. H. Hirschfeld, M.D.
O. A. Nelson, M.D.
Jack Rom, M.D.
Herbert Rosenbaum, M.D.
C. H. Ross, M.D.
L. F. Segar, M.D.
C. W. Sellers, M.D.
C. K. Stroup, M.D.
C. A. Thompson, M.D.
V. K. Volk, M.D.
S. C. Wiersma, M.D.

ANNUAL REPORT OF THE POSTGRADUATE MEDICAL EDUCATION COMMITTEE—1960-1961

The Committee on Postgraduate Medical Education met on December 8, 1960 and reviewed the postgraduate program. The reports from chairmen in the various centers indicate that the program was a successful one in all instances. These comments were reviewed and discussed. The

subjects presented, attendance, and speakers on the program for 1960-61 were as follows:

Centers	*Fall*	*Spring*	*1960-61*
Alpena	18		18
Battle Creek	116	63	122
Bay City	48	67	71
Cadillac		20	20
Jackson	57	40	69
Lansing	32	15	40
Midland	34	30	36
Muskegon	60	70	85
Niles	36	46	55
Port Huron	46		46
Roscommon	13	13	17
Traverse City	22		22
Upper Peninsula			
Escanaba	17	16	18
Houghton	18	15	23
Iron Mountain	14	16	18
Ironwood	12	16	16
Marquette	23	25	34
Menominee	23	22	34
Sault Ste. Marie	24	9	28
	613	483	772

The following subjects were presented:

Fall Program

Adolescence
Alcoholism: Liver Disease
Alcoholism: Psychiatric Problems
Arterial Surgery in Renal Hypertension
Auto-Immune Bodies—What Part do they Play in Disease?
Cardiac Arrhythmias
Clinical Use of Coronary Vasodilators
Current Concepts of Cardiac Function
Hemorrhagic Diseases
Open Heart Surgery
Orthopedics Pain Syndrome
Poliomyelitis Immunization in Early Infancy: Its Problems and Solution
Practical Aspects of Diabetic Management
Problems in Medical Education and How Physicians and Medical Societies Can Help
Radiation Therapy
Renal Aspects of Hypertension
Some Aspects of Radiation Therapy
Some Infectious Disease Problems
Subacute Thyroiditis
Thrombo-embolism
Thyroid Disease
Unusual Types of Heart Disease
Urology

Spring Program

Alcoholism: Liver Disease
Alcoholism: Psychiatric Problems
Arterial Surgery in Renal Hypertension
Auto-Immune Disease
Chemotherapy of Malignant Disease
Emotional Responses to Anesthesia and Surgery
Fractures in Children
Iron Deficiency Anemia—Its Diagnosis and Treatment
Low Hazard X-ray Diagnosis
Malignancies and Benign Growths of the Head, Face and Neck
Management of Acute Disorders of the Eye
Medical and Surgical Aspects of Cardiovascular Emergencies
Medical and Surgical Aspects of Operations in Poor Risk Patients
Poliomyelitis Immunization in Early Infancy
Problems in Medical Education and How Physicians and Medical Societies Can Help
Surgery of Skin Cancer
Surgical Risk in Cardiac Patients
Treatment of Injuries of the Hand
Unusual Types of Heart Disease
Vascular Headaches

The following named physicians participated in the teaching program: Carl E. Badgley, M.D., Wm. H. Beierwaltes, M.D., Bernard A. Bercu, M.D., Robert E. L. Berry, M.D., Hardee Bethea, M.D., Richard J. Bing, M.D., Muir Clapper, M.D., A. C. Curtis, M.D., Russell N. Dejong, M.D., Marion S. DeWeese, M.D., Stuart M. Finch, M.D., F. Bruce Fralick, M.D., Nicholas S. Gimbel, M.D., Ferdinand E. Greifenstein, M.D., Keith S. Henley, M.D., Fred J. Hodges, M.D., Paul E. Hodgson, M.D., Wm. N. Hubbard, M.D., Richard D. Judge, M.D., Donald R. Korst, M.D., James W. MacKenzie, M.D., Robert A. Moore, M.D., Russell L. Mustard, M.D., Reed M. Nesbit, M.D., Gerald A. O'Connor, M.D., Joseph L. Posch, M.D., Giovanni Raccuglia, M.D., Wm. S. Reveno, M.D., Ernest W. Reynolds, M.D., Julius Rutzky, M.D., Gordon H. Scott, Ph.D., A. Burgess Vial, M.D., Walter Whitehouse, M.D., Park W. Willis, III, M.D., James L. Wilson, M.D., George D. Zuidema, M.D.

The all day programs at Battle Creek in the fall and at Bay City in the spring were well attended and highly successful. Both centers expressed the wish to have such programs continued.

The possibilities of establishing other teaching centers in the State, as well as holding all-day programs in the present centers are constantly under consideration.

The matter of television programs sponsored by the State Society over local channels is being investigated. Detailed reports concerning the deliberations of the sub-committee, composed of Drs. Darling, Falls, Towsley, and Sheldon, will be made when more concrete arrangements have been completed.

The intramural courses at the University of Michigan, together with attendance, are listed below:

Intramural Courses	*Attendance*
Allergy	27
Anatomy	20
Basic Sciences and their Clinical Application	36
Cardiology	27
Clinical Conferences	28
Clinical Internal Medicine	56
Diagnostic Radiology	13
Diseases of the Blood	23
Diseases of the Heart	14
Electrocardiographic Diagnosis	44
Electrocardiography and Heart Diseases	20
Endocrinology and Metabolism	28
Foreign Physicians	8
Infertility and Endocrinology	36
Interns, Assistant Residents and Residents	385
Neurology, Clinical	25
Obstetrics and Gynecology	47

Ophthalmology	92
Orthopedic Surgery (Fractures)	16
Otolaryngology	39
Pathology	28
Pediatrics	38
Prevention and Early Recognition of Diseases	10
Psychiatry	20
Psychiatry for General Practitioners	4
Psychiatry for Internists	12
Pulmonary Diseases	14
Radioactive Isotopes, Clinical Use of	14
Recent Advances in Therapeutics	33
Rheumatology	15
Selected Clinical Topics	8
Surgical Pathology Slides	16
	1,196

The Committee wishes to thank all the physicians who participated in this teaching program. It recognizes that their splendid co-operation in this effort is in great part the key to its success. The Committee is grateful also for the support and encouragement given to this program by the Michigan Department of Health, the Wayne State University College of Medicine, and the University of Michigan Medical Center.

J. M. Sheldon, M.D., *Chairman*
E. I. Carr, M.D.
G. O. Clifford, Jr., M.D.
Milton A. Darling, M.D.
J. R. Heidenreich, M.D.
E. J. Neill, M.D.
C. Howard Ross, M.D.
D. J. Sandweiss, M.D.
R. M. Stow, M.D.
H. A. Towsley, M.D.
S. B. Winslow, M.D.
J. A. Witter, M.D.
H. H. Cummings, M.D., *Advisor*
A. E. Heustis, M.D., *Advisor*
W. N. Hubbard, Jr., M.D., *Advisor*
G. H. Scott, Ph.D., *Advisor*

ANNUAL REPORT OF THE SCIENTIFIC RADIO COMMITTEE—1960-1961

During the year 1960-61, 39 programs were prepared and tape recorded for lay education throughout the state of Michigan. These programs went out over the following stations at weekly intervals: WAGN—Menominee; WDOW—Dowagiac; WELL—Battle Creek; WUOM—University of Michigan; WTAC—Flint; WMRP—Flint; WHAK—Rogers City; WOAP—Owosso; WKZO — Kalamazoo; WMTE — Manistee; WMAB—Munising—WSIM—St. Joseph; SMBN—Petoskey; WMHE—Toledo, Ohio.

1. *Distribution and Advertising*—During the current year the programs have been carried by 21 stations in Michigan and one in Ohio. This has provided very adequate coverage for the entire state. Your committee would like to emphasize that there are about 110 radio stations in Michigan. We are currently distributing programs to nearly one-fourth of these stations. With more active participation on the part of members of the Michigan State Medical Society in communities where stations are not carrying the programs, it is felt that even a broader distribution might be accomplished. We, therefore, would urge those members to discuss with their radio station directors the possibility of carrying the Scientific Radio Program.

Date	*No.*	*Subject*	*Speakers*
10- 7-60	1	School Health Examination	Dr. Ernest H. Watson
10-14-60	2	Football Injuries	Dr. Louis P. Kivi
10-21-60	3	Physical Fitness in Athletic Competition	Dr. Thomas Peterson
10-28-60	4	Protection from Injuries for Athletes	Dr. Thomas Peterson
11- 4-60	5	The Significance of the Common Cold in Children and Adults	Dr. Davenport and Dr. Lowrey
11-11-60	6	The Significance of the Common Cold in Children and Adults	Dr. Davenport and Dr. Lowrey
11-18-60	7	Acne	Dr. Richard Harrell
11-25-60	8	Warts	Dr. Richard Harrell
12- 2-60	9	Menstrual Tension	Dr. Samuel J. Behrman
12- 9-60	10	Menstrual Tension	Dr. Samuel J. Behrman
12-16-60	11	Menstrual Tension	Dr. Waldo Bird
12-23-60	12	Aging	Dr. Fred Swartz
12-30-60	13	Aging	Dr. Fred Swartz
1- 6-61	14	Emotions and Parenthood	Dr. Stuart Finch
1-13-61	15	Emotions and Parenthood	Dr. Stuart Finch
1-20-61	16	Emotions and Parenthood	Dr. Stuart Finch
1-27-61	17	Emotions and Parenthood	Dr. Stuart Finch
2- 3-61	18	Human Genetics	Dr. J. V. Neel
2-10-61	19	Human Genetics	Dr. J. V. Neel
2-17-61	20	Human Genetics	Dr. J. V. Neel
2-24-61	21	The Use of the Atom in Medical Diagnosis	Dr. James Sisson
3- 3-61	22	The Use of the Atom in Treatment of Disease	Dr. Thomas Haynie
3-10-61	23	What Does Your Liver Do?	Dr. Robert J. Bolt
3-17-61	24	Diseases of the Liver	Dr. Robert J. Bolt
3-24-61	25	What is Infectious Hepatitis?	Dr. Robert J. Bolt
3-31-61	26	What Do Your Kidneys Do?	Dr. Carl Sauls
4- 7-61	27	Kidney Diseases in Adults	Dr. Carl Sauls
4-14-61	28	Kidney Diseases in Childhood	Dr. William Oliver
4-21-61	29	What Does Your Pancreas Do?	Dr. William Gracie
4-28-61	30	Diseases of the Pancreas	Dr. William Gracie
5- 5-61	31	Diabetes in the Adult	Dr. Robert Johnson
5-12-61	32	Diabetes in Childhood	Dr. George Lowrey
5-19-61	33	Cholesterol — What it does for you—What it may do to you	Dr. Park W. Willis
5-26-61	34	The Health Hazards of Being Fat	Dr. Park W. Willis
6- 2-61	35	How To Diet	Dr. Park W. Willis
6- 9-61	36	Hay Fever	Dr. Peter P. Barlow
6-16-61	37	Asthma	Dr. Peter P. Barlow
6-23-61	38	Eczema and Hives	Dr. Peter P. Barlow
6-30-61	39	The Hazards of Insect Bites	Dr. Peter P. Barlow

2. *Programming*—Our experience in the year 1959-60 suggested the need for series of talks on the same subject. This year efforts were made to provide, in so far as possible, series varying from two to five programs. Also, an attempt was made this year to consider organ disease. As indicated in the accompanying schedule, the kidneys, liver and pancreas were well discussed. According to a report from the University Broadcasting Service, there is an increasing interest on the part of the

listening audience for written copies of the talks given. Particular interest was shown to subjects pertaining to diabetes, problems of aging, liver disease and emotional and parental problems.

Your committee plans to give serious consideration to the possibility of developing a series of five-minute health talks, comparable to those put out by the American Medical Association. It seems that a number of stations have need for approximately five-minute fillers. We believe that offering such a series might encourage wider distribution.

Again, we should like to bring to the attention of the physicians in the State, the fact that the Public Relations Library of the Michigan State Medical Society has copies of each tape recording and also written summaries of each talk given. These could be used for reference material for physicians called upon to talk to local organizations.

It is anticipated that the budget for 1961-1962 will be approximately $1,500. This committee plans to have its annual meeting in the month of August to discuss programming for the ensuing year.

HARRY A. TOWSLEY, M.D., *Chairman*
S. J. BEHRMAN, M.D.
H. R. C. EDDY, M.D.
R. D. FEEHELEY, M.D.
R. H. HOWELL, M.D.
J. W. RICE, M.D.
G. H. SCOTT, PH.D.
J. M. SHELDON, M.D.
J. W. SIGLER, M.D.
R. W. TEED, M.D.

ANNUAL REPORT OF COMMITTEE ON RURAL MEDICAL SERVICE—1960-1961

The Committee attended the National Conference on Rural Health of the American Medical Association, held February 25-27, 1960 in Grand Rapids. Committee members took an active part in the Conference, as well as in planning the program and publicizing the meeting.

Members of the Committee also took part in the Michigan Health Council State Conference held in Flint, May 23-24-25, 1961. The Chairman of the Committee was one of the speakers at this Conference.

In addition, during the year a special reprint of the February 1960 number of the JOURNAL of the Michigan State Medical Society was widely distributed. This issue included an article by Chairman Harry B. Zemmer, M.D., concerning the M.D. Placement Program of the Michigan Health Council and various other Health Council activities relating to the health of the people in rural Michigan communities. The JOURNAL reprint also included an article on rural sanitation, written by J. K. Altland, M.D., Associate Commissioner of Health, and also a former Health Council President.

Throughout the year, Committee members and chairmen have continued to give guidance to the M.D. Placement Service and other programs on rural health conducted by the Michigan Health Council.

H. B. ZEMMER, M.D., *Chairman*
D. C. BLOEMENDAAL, M.D.
J. H. FYVIE, M.D.
T. B. HILL, M.D.
B. L. MASTERS, M.D.
R. E. PAXTON, M.D.
J. R. RODGER, M.D.
R. W. SPALDING, M.D.
C. F. WIBLE, M.D.

QUESTION

What is regarded as the biggest accomplishment of the AMA since its founding 114 years ago?

ANSWER

Its long and determined drive for higher standards of training for American doctors.

When a group of doctors from 22 states met in Philadelphia in May, 1847, to organize the American Medical Association, the first objective was a uniform and elevated standard of training leading to the degree of M.D. to be adopted by all medical schools in the United States.

The American Medical Association led a strong fight in the beginning to clean up the medical schools, which were nothing more than diploma mills. Progress was slow.

The big clean-up break came in 1909 when the late Abraham Flexner was asked by the Carnegie Foundation for the Advancement of Teaching to find out why medical schools smacked of shabby and sometimes shady business.

Flexner, working closely with the late N. P. Colwell, of the American Medical Association, faced a delicate task. The job was undertaken in a hostile era when physicians advertised their talents in the public prints, and school brochures were get-rich-quick lures for anyone with the tuition fee. At that time 165 medical schools offered courses in medicine.

When Dr. Flexner made his famous report, half of the nation's quack shops and diploma mills closed. But the historic report was even more dramatic. It blueprinted the future, and from that time on the standards for medical teaching in the United States became higher and higher and today doctors who graduate from the nation's 89 approved medical schools are better trained than anywhere else in the world.

A study of the Association of American Medical Colleges shows that 62 per cent of the medical students in the 1959 graduating class were married. This figure notes a sharp rise in the number of married medical students and an increase, too, in the cost of medical education to the student.

Michigan Legislative Session Reviewed

During its regular 1961 session the Michigan Legislature considered nearly 1,100 bills and 240 resolutions, one in twenty of which had direct medical implications. Over 80 per cent of these either died in committee or, having passed one House, died in the other. The 71st Legislature was preoccupied with taxation, appropriations, and the imminent Constitutional Convention—first in 53 years.

Legislative Reports from MSMS reflected repeated attempts by chiropractors to expand privilege and practice. House Bill 384, which would have broadened the definition of chiropractic, passed the House but died in the Senate. Senate Bill 1127, designed to license physical therapists, was preempted by chiropractic partisans by an amendment attempting to legalize all its "present practices," thus killing this bill in the House. Finally, an eleventh-hour amendment was placed on Senate Bill 1039, the Medical Aid to the Aged bill, to make chiropractic services "medical aid"—sending the bill to two conferences between House and Senate before legislators removed the amendment and passed the bill as endorsed by MSMS.

In other areas, a bill was amended which, if passed, would have required every physician to obtain a second "dangerous drug license" from the State Board of Pharmacy.

The Public Health appropriation was amended to permit payment of physicians' bills rendered in excess of 30 days during fiscal year 1960-61, for services to crippled and afflicted children. While the ceilings on payment to physicians under these acts, unchanged since 1948, were not raised encouraging progress was made toward general legislative acceptance of the need to raise them in the 1962 session.

Two bills, one to establish minimal standards for ambulances and another to improve the law for testing intoxicated drivers, failed of passage although the latter passed the State Senate.

Despite appearances by opthalmologists before both House and Senate committees and later before the Governor requesting his veto, House Bill 574 became law and established contact lens work in the definition of optometry.

Attempts to loosen the Psychologists Registration Act of 1959 met defeat in the Legislature, and new licensure laws for hospitals and for dispensing opticians died in first committee. A bill aimed at control of cancer quackery, House Bill 44, was deferred pending further study of similar legislation in three other States.

Three resolutions of particular interest were passed creating special study committees—one of the Blue Plans, one of the optical sciences, and one of the Crippled and Afflicted Children's Acts.

Veteran observers generally agree that the 1961 session, a full month shorter than the usual "odd-year" sessions, has been the most hectic and arduous in memory.



MICHIGAN DEPARTMENT OF HEALTH
ALBERT E. HEUSTIS M.D., State Health Commissioner

Howell Sanatorium Ends Tuberculosis Treatment Career

Conversion of the Michigan State Tuberculosis Sanatorium at Howell into an institution for the treatment of mentally ill persons represents a tribute to all Michigan people and organizations who have contributed to the progress made against TB over the years.

Included in the tribute would be public health workers, the medical profession, drug research scientists, the Michigan Tuberculosis Association and its affiliates throughout the state, the thousands of Michigan residents who have been interested in tuberculosis over the years, and the TB patients themselves who have co-operated by submission to lengthy hospitalization to regain their health and protect others from contracting the disease.

Closing of the Howell facility for treating TB unfortunately does not signal the beginning of complete victory over tuberculosis in Michigan. It does, however, hail the great strides that have been made in treating the disease so that today treatment is so effective an average of two patients are cured a year for every TB hospital bed. This great progress in treatment, resulting in much shorter periods of hospitalization, is why it has become possible to discontinue TB treatment at Howell and turn the facility over to the Department of Mental Health to meet an urgent health need in Michigan.

The Howell sanatorium was the first state institution authorized by the legislature for the treatment of tuberculosis. This was in 1905 and the sanatorium started operation in 1907 with 16 beds in a frame, "shack-like" structure. Today, it is a modern, three-story stone and brick structure with a 358-bed capacity.

Discontinuing treatment of tuberculosis at Howell will not jeopardize the availability of beds for TB patients in Michigan. There are still three state-operated sanatoriums, located at Kalamazoo, Gaylord, and Hancock, and 13 county facilities with a total of nearly 3,000 beds for treatment of tuberculosis victims. We are sure this will be entirely adequate for our future needs. More than 6,000 persons received treatment in these facilities in 1960.

All of the state sanatoriums have been dual treatment facilities since 1959 when a program went into effect to transfer mental patients to these facilities to use beds vacated by tuberculosis patients. The program has worked exceptionally well.

At the time of the conversion of Howell to a mental institute, there were about 160 mental patients hospitalized there, compared to about 100 TB patients. The majority of the tuberculosis patients were transferred to Detroit's Herman Keifer Hospital for needed continuing treatment, when the Common Council of that city approved enlargement of the hospital's service area to include the major portion of the area formerly served by Howell.

During its 54 years of operation, the Howell sanatorium treated more than 12,000 tuberculosis patients. It was the first state tuberculosis sanatorium established and the first to be disbanded for treatment of patients with this disease.

The Howell institution's lifetime as a tuberculosis treatment facility saw three distinct eras of ways of treating tuberculosis. The first was the "fresh air" theory and the original open air shacks were surely designed to provide an abundance of fresh air in winter and summer alike; the second was a "sun exposure" theory, in which patients were encouraged to sun-bathe for long periods of time each day—in direct sunlight in the summer and under artificial lamps in the winter time. Neither treatment method hurried a patient's recovery. Bed rest was still the element which arrested the disease and this often required literally years of hospitalization.

The big breakthrough in the treatment of TB came in the mid 40's with the discovery of the amazing arresting powers of certain potent drugs developed during World War II. Even though these drugs do not actually kill the tubercle bacilli, they do have the power of halting the further spread of the germ, thereby localizing the infection.

A sanatorium such as the one at Howell, and the many people who have worked there during its 54 years of service, can be proud of the important role played in the fight against tuberculosis and the returning of thousands of persons with the disease to normal and productive living. Though it may be forgotten by many in the years to come that Howell was once the location of one of Michigan's largest sanatoriums for the treatment of tuberculosis, those 12,000 or so Michigan persons who were made well there and returned to their families and communities will never forget. To them, Howell is "a pretty nice place to be from."

MHC Establishes Health Hall of Fame

A highlight at the 1961 annual Michigan Health Council State Conference was the establishment of a "Michigan Hall of Fame in Health."

Sidney E. Chapin, M.D., Dearborn, MHC president, announced the recipients of the first five "Hall of Fame in Health Awards." Elected this year were the late L. Fernald Foster, M.D., the late W. K. Kellogg, Frederick A. Coller, M.D., Thomas Francis, Jr., M.D., and William J. Norton. Doctor Foster was one of the founders of the Michigan Health Council and served for many years as secretary of the MSMS. Mr. Kellogg founded the W. K. Kellogg Foundation of Battle Creek which during the past 30 years granted nearly $300,000,000 to health, education and welfare programs. Doctor Coller was recognized for his outstanding contributions in the specialty of surgery and Doctor Francis for his leadership in the field of epidemiology. Mr. Norton is nationally-known for his service as president of the Children's Fund and his work in the development of the United Community Services in Detroit as well as with other health and welfare foundations.



It was a happy time when the Michigan Health Council presented its first "Hall of Fame in Health Awards"—left to right are William J. Norton; Andrew Pattullo who accepted in behalf of the late W. K. Kellogg; Mrs. L. Fernald Foster who received the award given her late husband; Thomas Francis, Jr., M.D.; Harry A. Towsley who accepted on behalf of Frederick A. Coller, M.D., and Hugh W. Brenneman, who made the award presentations at the MHC banquet.



Edward R. Annis, M.D., of Miami, Florida, was given a standing ovation prior to and after his banquet talk at the conference, held this year at the Ballenger Field House on the campus of the Flint Junior College. Several hundred doctors, their wives and the presidents of nearly every health society and association in Michigan, were in attendance to hear Doctor Annis and more than 45 other program participants during the three-day conference.



Conferring at the MHC banquet with the speaker, Edward R. Annis, M.D., center, native of Detroit and now of Florida, are Sidney E. Chapin, M.D., Dearborn, MHC president, and William McNary, right, Detroit, MHC president-elect.

Doctor Annis, who became nationally known early this year for his debates with Walter Reuther and Senator Hubert Humphrey, again attacked arguments offered by critics of the present system of medical care in the United States. He stated that medical care in the United States is expensive, because Americans want the best possible care and they want "jet-age medicine." Hospitalization and medical care cost a lot, Dr. Annis admitted, "but they are worth a lot."

Mrs. Paul Ivkovich, president of the Woman's Auxiliary to the Michigan State Medical Society, served as chairman of the School Health Conference.

Kenneth H. Johnson, M.D., president of MSMS, served as chairman of the May 25 program about the "President's Program." A. Hazen Price, M.D., of Detroit, served as chairman of the Conference of the Joint Council to Improve the Health Care of the Aged. Members of the panel included Allan E. Voigh, M.D., of San Francisco, chairman of the California Joint Council; Harry B. Zemmer, M.D., Lapeer, president emeritus of the Michigan Health Council; C. Howard Ross, M.D., Ann Arbor, president of the Michigan Academy of General Practice; Jack DeTar, M.D., Milan, past-president, American Academy of General Practice, and A. H. Hirschfeld, M.D., Detroit, member, Geriatrics Committee of the MSMS.

Harry A. Towsley, M.D., associate director, postgraduate medicine, University of Michigan, was the general chairman of the conference. Hugh W. Brenneman, public relations counsel of the MSMS and secretary-trustee of the Michigan Health Council, served as banquet toastmaster.

Wayne Alumni Day Tops All Records

The 93rd Annual Alumni Reunion of Wayne State University College of Medicine, May 3, commemorated three professors who died in 1960—Osborne A. Brines, M.D., clinical pathology, and past president of the International Society of Clinical Pathology; Charles G. Johnston, M.D., surgery; and Gordon B. Myers, M.D., internal medicine research.

Most of the speakers, in giving their addresses, mentioned close association with these outstanding professors.

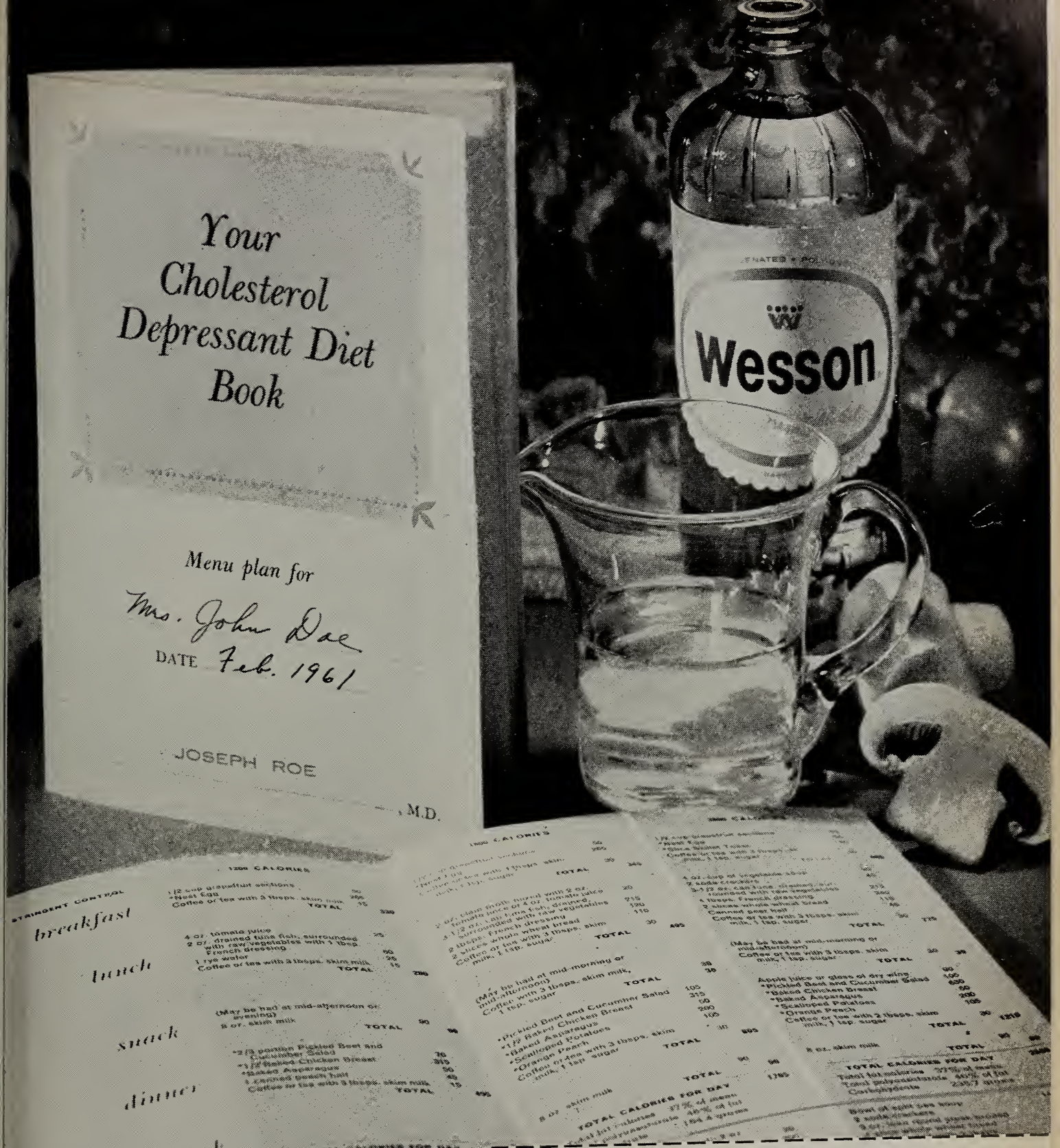
An attendance of 393 topped all previous Alumni Day records.

At the evening banquet, a "Distinguished Service Citation" was given to Don W. McLean, M.D., in recognition of a long list of major accomplishments, including the presidency of the Wayne County Medical Society.

The Golden Anniversary Diplomas were given to John D. Buck, M.D., Saline; Henry R. Carstens, M.D., Birmingham; E. Wilbur Caster, M.D., Oak Park; Harry Dibble, M.D., Detroit; Raymond S. Goux, M.D., Detroit; Elmer H. Hanna, M.D., Detroit; Glenn C. Hicks, M.D., Jackson; Robert D. Scott, M.D., Flint; James R. Stringham, M.D., Cheboygan; Earl P. Bunce, M.D., Trufant; and Edwin L. Robinsons, M.D., Detroit. Out-of-state doctors so honored included Garner Byington, M.D., Campbell, California; Darcy M. Dayton, M.D., Tacoma, Washington, and Louis A. Wardell, M.D., New York City.

Named WMA Secretary

Harry S. Gear, M.D., international leader in the field of hygiene and tropical medicine, is the new secretary general of The World Medical Association. Dr. Gear was director of pneumoconiosis research, Council for Scientific and Industrial Research-Industrial Medicine in Johannesburg, South Africa.



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HEART BEATS

(This material is provided by the Michigan Heart Association)

Annual "Michigan Heart Day"

Plans for the Third Annual Michigan Heart Day are under way for Saturday, February 10, 1962, at the Statler-Hilton Hotel, Detroit. Three speakers will be presented in the morning sessions, on problems in clinical cardiology. The afternoon session will include a panel discussion, "Unexplained Big Heart."

Further details will be reported later.

AHA Scientific Sessions

Six sessions on clinical cardiology will be included in the 34th annual Scientific Sessions of the American Heart Association, October 20-22, at the Americana Hotel, Bal Harbour, Miami Beach, Florida. A panel or symposium including related investigative work will be presented at each clinical session.

In addition, a total of 18 other scientific sessions will be held concurrently during the three-day program.

A tentative outline of the program follows:

Friday, October 20: The sessions on clinical cardiology include: Conner Memorial Lecture, by Clark H. Millikan, Professor of Neurology, Mayo Clinic; a symposia on "Contribution of Phonocardiography to Auscultation," and on "Coronary Arteriography;" a lecture, "Biplane Angiography" by Dr. Herbert L. Abrams, Assistant Professor of Radiology, Stanford Medical Center. Concurrent sessions are scheduled on arteriosclerosis, on biophysical methods in the study of circulation, and on high blood pressure research. A program for nurses is also scheduled concerning cardiovascular research as it relates to care of the cardiac patient.

Saturday, October 21: The clinical sessions will include: Panel, "Ventricular Arrhythmias;" lecture, "Closed Chest Cardiac Resuscitation" by Dr. James R. Jude, Johns Hopkins Hospital; Brown Memorial Lecture, "Physiology of the Peripheral Circulation," by Dr. Robert W. Wilkins, Professor of Medicine, Boston University School of Medicine; symposium, "Renal Failure." Simultaneous scientific sessions will be held in the fields of basic science, cardiovascular surgery, and on "Compensable Heart Disease, Strain and Trauma."

Scheduled for Saturday evening are "Cardiac Conferences," which will give physicians an opportunity to participate in small group discussions on timely cardiovascular problems.

Sunday, October 22: Subjects for the clinical sessions include: symposium, "The Role of Hormones in Heart Failure;" panels, "Ventricular Hypertrophy and Bundle Branch Block" and "Newer Electrocardiographic Lead Systems;" lecture, "ECG Clues Suggesting Myocardial Infarction" by Dr. Junior A. Abildskov, Assistant Professor of Medicine, State University of New York College of Medicine. Concurrent sessions will be held on rheumatic fever and congenital heart disease and on cardiovascular surgery. Cardiovascular films, with introduction and commentary by the author or other authority on the subject of each film, will be shown throughout Sunday.

As in previous years, scientific and industrial exhibits will be on display.

Registration forms, which include applications for hotel reservations, are available from the American Heart Association, 44 East 23rd Street, New York 10, New York.

MHA Research Grant Applications

Applications for 1962-63 MHA grants-in-aid may be obtained by request directed to the Medical Director, Michigan Heart Association, 3919 John R, Detroit 1, Michigan. The deadline for submission of application is December 15, 1961. Investigators presently holding MHA grants will be reminded of the deadline by letter later in the year.

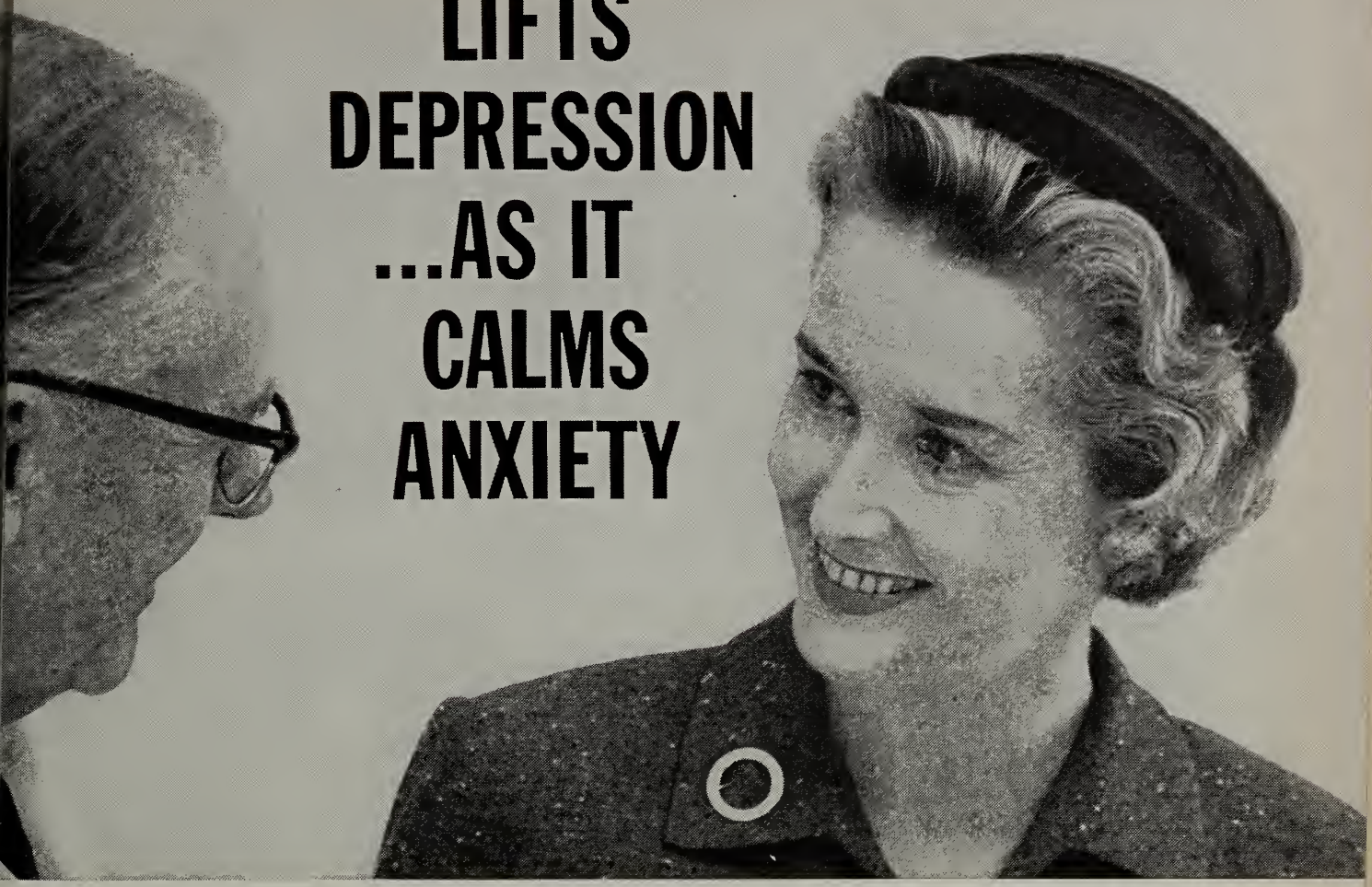
Materials from Heart Association Journals Made Available in Volume Form

Four new volumes bringing together materials from its scientific journals, *Circulation* and *Circulation Research*, are being published by the American Heart Association, as follows:

"Hypertension—Chemical and Hormonal Factors," Volume IX of the Proceedings of the Association's Council on High Blood Pressure Research, is a compilation of papers given by leading authorities in the

(Continued on Page 944)

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Materials from Heart Association Journals

(Continued from Page 942)

field at the Council's annual meeting in Cleveland last November ($2.50).

"Symposium on Coronary Heart Disease" is the second in the AHA monograph series, a compilation of articles originally published in *Circulation* from August, 1960-January, 1961. Authors include Drs. Paul D. White, Herrman L. Blumgart, Paul M. Zoll, J. Scott Butterworth, Edmund H. Reppert, Jr., Robert E. Olson, George S. Kurland, A. Stone Freedberg, Irving S. Wright, Anthony P. Fletcher, Sol Sherry, Howard B. Sprague, E. Cowles Andrus , Eugene Lepeschkin and Bruce Logue ($2.50).

"Cardiovascular Abstracts I—1960" contains more than 700 abstracts of significant papers on cardiovascular subjects published in 86 scientific journals in the U. S. and abroad. It is edited by Dr. Stanford Wessler with a forward by Dr. J. Scott Butterworth, President-Elect of the American Heart Association ($2.75).

The above three volumes are now available from the Distribution Department, American Heart Association, 44 East 23rd Street, New York 10, New York, or through the usual channels.

Scheduled for publication in August is a symposium, "The Myocardium—Its Biochemistry and Biophysics" ($2.50). It will include presentations given at a New York Heart Association event in December, 1960, by Drs. Hugh E. Huxley, Don W. Fawcett, Johannes A. G. Rhodin, George E. Palade, Manuel F. Morales, Shizuo Watanabe, Richard J. Podolsky, Wilfried F. H. M. Mommaerts, Robert F. Furchgott, Charles F. Lyman, Irwin R. Konigsberg and Robert L. DeHaan. The symposium will also be published as a supplement to the August issue of *Circulation*.

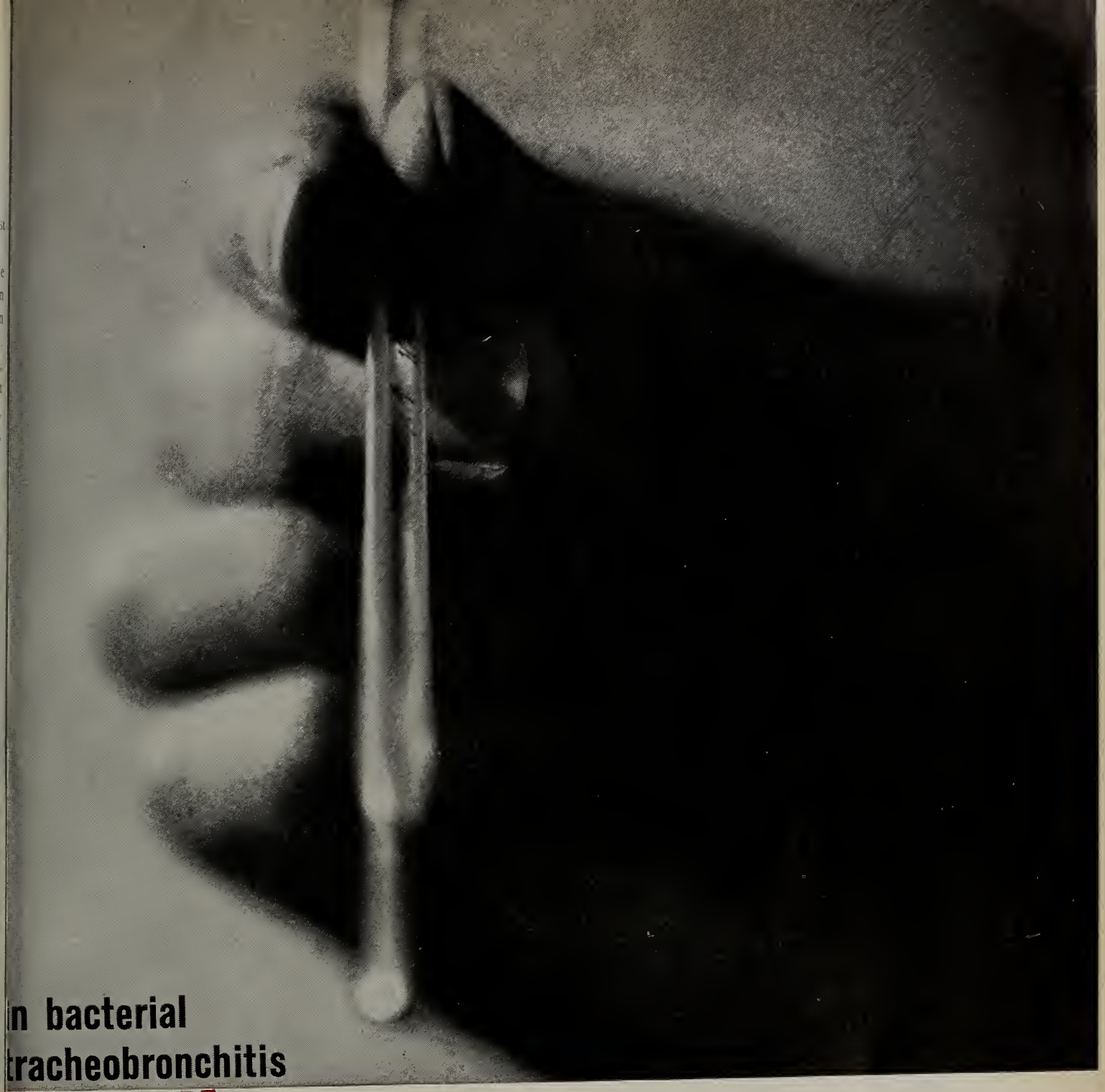
AHA Council on Arteriosclerosis to Meet October 18-20 in Miami

The Council on Arteriosclerosis of the American Heart Association will hold its Annual Meeting on October 18-20 at the Hotel Balmoral, Bal Harbour, Miami Beach, Florida, immediately preceding the AHA's annual Scientific Sessions in the same city, October 20-22.

For information, write Jeremiah Stamler, M.D., Chicago Board of Health, 54 West Hubbard Street, Chicago 10, Ill.

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Urticaria and maculopapular dermatitis, a few cases of leukopenia and agranulocytosis have been reported in patients treated with Albamycin. Most of these side effects usually disappear upon discontinuance of the drug.
Caution: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken.
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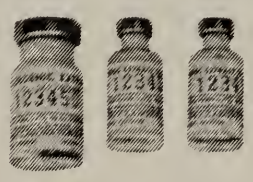
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COMMUNICATIONS

Dear Mr. Burns:

Considerable attention has been given to solving the health needs of our elderly citizens in relation to the adequacy or inadequacy of the HR 12580 (Kerr-Mills Bill) and subsequent Michigan Senate Bill 1002 entitled Medical Assistance to the Aged.

For your background information, we find that we have 22,000 persons over age 65 in this industrial community, excluding approximately 2000 people receiving old age assistance. It is estimated that 12 per cent of these senior citizens will require hospitalization per year which preconceives 2700 persons will be or should be in a hospital during this year.

Of the 22,000, 60 per cent have private insurance, which means 1600 of the 2700 expected to be hospitalized are of private insurance status. An additional 20 per cent have incomes greater than $2500 per year which indicates that about 500 out of the 2700 people requiring hospitalization would be able, either personally or via insurance, to take care of their own medical care expenses. We are then left with 600 persons requiring hospital care who might benefit from the Medical Assistance to the Aged Bill.

The present rate of applying for assistance under this Act is 2.6 applications per working day, which totals about 600 per year. During a 30-day period, 20 per cent or 10 applications out of 50 were refused because their assets or income exceeded the limits allowed by the Michigan bill. This percentage is confirmed by a state survey.

Impressions:

1. The MAA (Medical Assistance to the Aged) program is doing well in serving the needs of our medical indigents. 80 per cent of those applying are getting assistance. Over a one-year period, probably 20 per cent or 120 persons will be ineligible because their assets are in excess of the limits of Senate Bill 1002. It is possible that the ineligible applicants could only be assisted by measures which would force our independent citizens to drop their hospitalization insurance.

2. We are favorably impressed in Genesee County with the cooperation of the Bureau of Social Aid and the County Welfare Department in implementing this Act.

3. We would like to suggest that an addition be made to the Rules and Regulations of this Act, to specify that the transfer of patients to and from hospitals, county facilities, and nursing homes be done only with the approval of the attending physician (licensed to practice in the state of Michigan).

Sincerely yours,
J. C. Rawling, M.D.
Chairman, Legislative Committee
Genesee County Medical Society

Flint, Michigan
May 4, 1961

RESEARCH GRANT RENEWED—Ronald Lippitt and Stephen Withey of The University of Michigan Institute for Social Research have received a renewal grant of $25,000 from the U.S. Public Health Survey to support research conducted by Inter-Center Program on Family, Youth and Children.

Brief and to the Point

HONORED BY REGENTS—Edwin L. Thirlby, M.D., who has served the Traverse City area for 60 years, was honored recently at a community dinner when he received a University of Michigan Regents' Citation of Honor for his distinguished service to higher education. The presentation, made by U-M President Harlan Hatcher, recognized Doctor Thirlby for the motivation he has provided for the postgraduate medical education program conducted by the University at Traverse City. Doctor Thirlby was "Michigan's Foremost Family Physician" in 1960.

* * *

"CITIZEN OF THE YEAR"—Herman Meinke, M.D., Hazel Park, recently received a citation by the Hazel Park Veterans of Foreign Wars for his outstanding service to the community. Specifically, he was cited for his "humanitarian efforts in behalf of at least two generations of Hazel Park families."

* * *

"THE BISHOP LECTURE"—The lecture at the annual Doctors' Dinner-Lecture program at the Almont Community Hospital is to be known as "The Bishop Lecture," in honor of G. Clare Bishop, M.D., longtime Almont doctor. The Almont Hospital staff voted that Dr. Bishop may name any nationally-known medical authority to give the annual lecture, and the hospital staff will finance the cost.

* * *

BUSY TIME—Among the busy Michigan M.D.'s this month is Norman D. Nigro, M.D., Detroit, who is secretary of the American Proctologic Society. He has a major role to play in connection with the annual meeting of the Society in Pittsburgh, June 21-24.

* * *

INJURY SURVEY—A recent report by the United States National Health Survey finds that the injury rate per 1,000 population for Detroit is 157. That rate is less than one half that of San Francisco. San Francisco had the highest rate of eight large cities in the survey —333 injuries per 1,000. Detroit's rate was the lowest. Chicago's was the second highest—264 per 1,000.

* * *

HEADS SURGERY—Alan Thal, M.D., University of Minnesota, has been named chairman of the department of surgery at Wayne State University's College of Medicine. He will head a department which gained national prominence through the leadership of Dr. Charles G. Johnston who died in 1960.



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RECEIVES GRANT—The Department of Health, Education and Welfare has granted Wayne State University College of Medicine over $48,000 for two studies. $26,335 is aimed at determining the effects of acceleration on the human skeleton. Whiplash injuries in particular will be studied. F. Gaynor Evans, M.D., professor of anatomy at the University of Michigan, will cooperate.

The second grant is $21,729 for a deformation study of the bones of the face. The study will try to determine how bones of the face deform and fracture under loads such as auto accidents.

* * *

DOCTORS CERTIFIED—The American Board of Obstetrics and Gynecology certified the following Michigan doctors on April 15: Vernon V. Bass, M.D., Saginaw; Abraham Blumer, M.D., Detroit; Donal T. Conley, M.D., Marquette; Martin H. Daitch, M.D., Livonia; Herman C. Eldersveld, M.D., Grand Rapids; Donald H. Endean, M.D., Holland; Robert K. Ferguson, M.D., Kalamazoo; Harry C. George, M.D., Lansing; Harold Glen, M.D., Detroit; Alan Cecil Lakin, M.D., Detroit; Therion D. Loughrin, M.D., Lansing; Henry Ehrlicher Malcolm, M.D., East Lansing; John Michael Malone, M.D., Detroit; Cornelius Aurelius Mavori, M.D., Lincoln Park; Gena Rose Pahucki, M.D., Ann Arbor; Theresa Rita Palaszek, M.D., Grand Rapids; Charles Peake, M.D., Kalamazoo; Thomas J. Petrick, M.D., Lincoln Park; James F. Pingel, M.D., Southfield; Edmund J. Robson, M.D., Lansing; Robert F. Rourke, M.D., St. Clair Shores; Ronald E. Rourke, M.D., St. Clair Shores; Thomas J. Sansone, M.D., Pontiac; Darrell E. Statzer, M.D., Detroit; Charles D. Stephenson, M.D., Battle Creek; Creighton A. Wabener, M.D., Traverse City; Joseph J. Woods, M.D., Detroit; and William J. Yetzer, M.D., Dearborn.

* * *

CONGRESS ON MEDICAL QUACKERY—The American Medical Association will hold a Congress on Medical Quackery in conjunction with the Federal Food and Drug Administration in Washington, D. C., October 6-7 at the Sheraton-Park Hotel. Since medical quackery is a real problem in every state, the Congress will present new ideas and better methods of combating this evil. For copy of program, write F. J. L. Blasingame, M.D., Executive Vice President, AMA, 535 North Dearborn Street, Chicago 10.

* * *

U-M PROMOTIONS—University of Michigan Medical School has promoted the following doctors to the rank of professor—E. Richard Harrell, Jr., M.D. (Dermatology), Stefan S. Fajans, M.D. (Internal Medicine), Kenneth P. Mathews, M.D. (Internal Medicine), Gardner M. Riley, M.D. (Obstetrics and Gynecology); to associate professor—C. William Castor, Jr., M.D. (Internal Medicine), F. James Conway, M.D. (Internal Medicine), Robert D. Johnson, M.D. (Internal Medicine), William M. Mikkelson, M.D. (Internal Medicine), George W. Morley, M.D. (Obstetrics and Gynecology), Albert V. Hennessy, M.D. (Pediatrics and School of Public Health), William J. Oliver, M.D. (Pediatrics), Makepeace U. Tsao, M.D. (Pediatrics), Saul I. Harrison, M.D. (Psychiatry), Kenneth A. Kooi, M.D. (Psychiatry), and Joe D. Morris, M.D. (Surgery).

(Continued on Page 952)

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"... hydroxyzine [ATARAX] is of considerable therapeutic value in the treatment of psychoneurosis...." Most patients "... with commonly encountered neuroses such as anxiety states occurring in business executives, in laborers dissatisfied with their jobs, in patients experiencing emotional upheavals caused by disturbed family situations, and in those with associated organic disease..." were treated successfully.[1]

calming, seldom impairing mental acuity

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References: **1.** Garber, R. C.: J. Florida M. A. *45*:549 (Nov.) 1958. **2.** Lipton, M. I.: Pennsylvania M. J. *64*:60 (Jan.) 1961. **3.** Ayd, F. J., Jr.: Psychotropic Drugs, S. Garattini and V. Ghetti, eds., New York, Elsevier Publishing Co., 1957, p. 548. **4.** McGettigan, D. L.: West. Med. *1*:8 (Jan.) 1960.

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(Continued from Page 950)

ELECTED COUNTY SUPERVISOR—W. G. Gamble, Jr., M.D., Bay City, was elected this spring as representative of the city's second ward to the Bay County Board of Supervisors.

* * *

ON COLLEGE BOARD—Two doctors are serving on the governing board of the new Delta College, near Bay City-Saginaw. Elected to the board are Fred J. Chapin, M.D., Bay City, and Donald C. Durham, M.D., Saginaw.

* * *

NY LEADER—Henry I. Fineberg, M.D., immediate past-president of the Medical Society of the State of New York, is the new chief administrative officer of that society. Long active in organizational affairs, Doctor Fineberg was chairman of the New York delegation to the AMA House of Delegates.

* * *

SPEAKER—John B. Bryan, M.D., Detroit, was a speaker at the spring meeting of the Michigan Dietetic Association in Detroit. He discussed electrolyte metabolism.

* * *

ON NATIONAL PROGRAM—Geoffrey L. Brinkman, M.D., Detroit, explained "The Importance of Biopsy of Non-Palpable Scalene Nodes in Bronchogenic Carcinoma" at the recent joint annual meeting of the National Tuberculosis Association, American Thoracic Society and National Conference of Tuberculosis Workers at Cincinnati.

* * *

ANNIS NAMED—Edward R. Annis, M.D., of Miami, Florida, a leading spokesman for the nation's private physicians, has been appointed editor-at-large of the magazine *Medical Economics*. Dr. Annis will write a biweekly column for the publication.

* * *

MEDICAL MEETINGS, U.S.A.

American Hospital Association, Sept. 25-28, Atlantic City, New Jersey.

College of American Pathologists, Sept. 30-Oct. 3, Seattle, Washington.

American Society of Clinical Pathologists, Sept. 30-Oct. 8, Olympic Hotel, Seattle, Washington.

College of American Pathologists, Oct. 1-7, Olympic Hotel, Seattle, Washington.

American Academy of Pediatrics, Oct. 2-5, Palmer House, Chicago, Illinois.

American College of Surgeons, Oct. 2-6, Conrad Hilton Hotel, Chicago, Illinois.

American Academy of Ophthalmology and Otolaryngology, Oct. 8-13, Palmer House, Chicago, Illinois.

Fourth International Congress of Allergology, Oct. 15-20, the Hotel Commodore, New York, N. Y.

American Heart Association, 34th Annual Meeting, Oct. 20-24, Miami Beach, Florida.

American Society of Anesthesiologists, Inc., Oct. 22-27, Statler Hilton, Los Angeles, California.

American Medical Association, Clinical Meeting, Nov. 27-30, Denver, Colorado.



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Michigan Authors

Andrew F. Caughey, Jr., Detroit, "The X-Ray Signs of Fetal Death," *Obstetrical and Gynecological Survey*, April, 1961.

E. L. Quinn, M.D. and **J. M. Colville, M.D.,** Detroit, "Subacute Bacterial Endocarditis," *The New England Journal of Medicine*, April 27, 1961.

David Gage, M.D., Lansing, "Classification of Cardiacs," *Industrial Medicine and Surgery*, May, 1961.

Harper Hellems, M.D., Detroit, "Types of Heart Problems," *Industrial Medicine and Surgery*, May, 1961.

George L. Nardi, M.D., Boston, and **George D. Zuidema, M.D.,** Ann Arbor, "The Post-operative Use of Dextro Pantothenyl Alcohol," *Surgery, Gynecology and Obstetrics*, May, 1961.

R. S. Sethi, M.D. and **John R. MacDonald, M.D.,** Detroit, "Adrenal Apoplexy," *Harper Hospital Bulletin*, March-April, 1961.

John W. Sigler, M.D., Maryland, and **Dwight C. Ensign, M.D.,** Detroit, "Common Rheumatic Disorders, Part II: Rheumatoid Arthritis," *American Practitioner and Digest of Treatment*, May, 1961.

Irving I. Edgar, M.D., Detroit. "Modern Surgery and Lord Lister," *Journal of the History of Medicine and Allied Sciences*, Volume XVI, Number 2, 1961.

J. Alan Gray, M.D., Battle Creek, "Gangrene of the Genitalia as Seen in Advanced Periurethral Extravasation with Phlegmon," *Journal of Urology*, December, 1960.

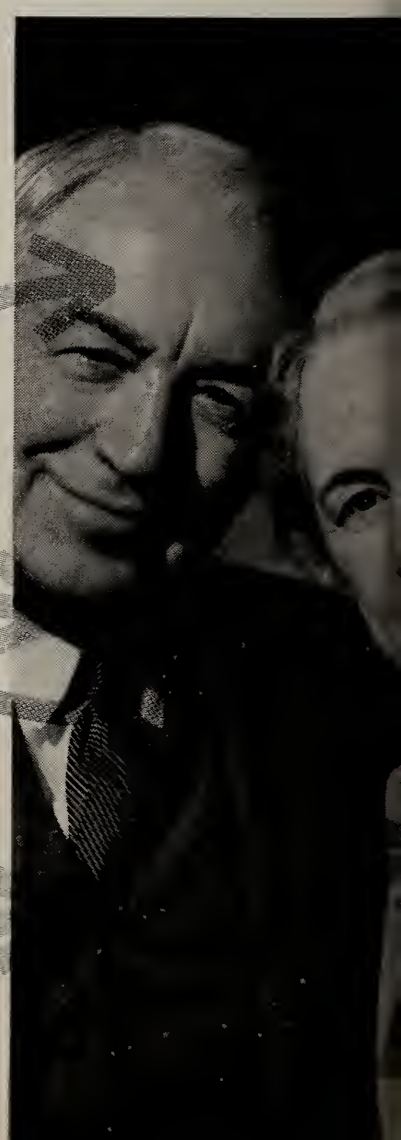
Bruce Proctor, M.D., Detroit, "Chronic Progressive Deafness," *Archives of Otolaryngology*, May, 1961.

Rudolf E. Wilhelm, M.D., Detroit, "Bronchial Asthma," *The Journal of the Louisiana State Medical Society*, May, 1961.

FILMS AVAILABLE—Audio-visual refresher courses are being prepared under the direction of the College of Medicine, Wayne State University Utilization Center. A number of physical diagnosis courses have been prepared including "Introduction to Speech Disorders," "Communicable Disease," "Gait and Musculo-skeletal Disorders," "Disorders of Mobility," "The Ear and Hearing," and "The Larynx." This program has been carried out under the supervision of Frederick J. Margolis, M.D., Kalamazoo. The films may be obtained on a rental basis from the Wayne State University Audio-Visual Utilization Center. This project has been sponsored by Ciba Pharmaceuticals, Inc.

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increases blood flow to the brain in the "senility syndrome" associated with cerebrovascular insufficiency



IN MEMORIAM

ROBERT P. GUNN, M.D., fifty-four, Bay City physician for the past sixteen years, died in a plane crash on May 15, 1961.

Doctor Gunn was a staff anesthetist at Bay City's General and Mercy Hospitals. He was a graduate of Wayne State University and its College of Medicine, and the University of Michigan. At Wayne, he was selected as one of the top ten athletes in the history of the school for his ability as a basketball center.

FREDERICK S. LEEDER, M.D., fifty-seven, Lansing, nationally known epidemiologist and director of the state health department's division of disease control, records and statistics, died May 17, 1961.

Born in Saskatoon, Canada, he graduated from the University of Toronto medical school in 1928. He received his doctorate in public health at the same school in 1939, also taking graduate work at Harvard University School of Public Health.

Prior to coming to Michigan, Doctor Leeder was associated with public health units in Massachusetts and New York. In 1934, he became Allegan County health officer, and from 1939 to 1941, served in the Branch County health department. In 1942 he became assistant director of the State Health Department's Bureau of epidemiology, becoming its director in 1945, when it was renamed the Division of Disease Control, Records and Statistics.

Memberships included the American College of Preventive Medicine, American Public Health Association, American Board of Preventive Medicine and Public Health, Michigan Public Health Association, Michigan Association of the Professions, New York Academy of Sciences and the Royal Society of Health, Canada.

I. ALLEN SHAPIRO, M.D., fifty-five, Detroit physician for more than twenty-five years, died May 21, 1961.

A graduate of Wayne State University College of Medicine, Doctor Shapiro served in the South Pacific during World War II. Following the war he became associated with the Livernois Clinic in Detroit. He was a member of Phi Delta Epsilon fraternity, and the Academy of Pediatrics.

DELBERT E. SILER, M.D., fifty-three, Saginaw urologist, died April 26, 1961.

Born in Stockbridge, Michigan, Doctor Siler attended UCLA and St. Mary's College and was graduated in 1937 from Marquette University medical school. He served his internship at Henry Ford Hospital, Detroit, and his residency at Wayne County General Hospital. Later, he did postgraduate work at the University of Georgia.

He came to Saginaw from Bay City in 1947. Memberships included the American Board of Urology, North Central Section of the American Urological Association and Detroit Urological Society.



Inadequate cerebral blood flow—often due to cerebral arteriosclerosis—may result in the "senility syndrome" with its pattern of mental confusion, memory lapses, depression, fatigue, apathy and behavior problems.[1-3]

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references: 1. Madow, L.: Penn. M. J. 62:861, June 1959. 2. Stieglitz, E. J.: Geriatric Medicine, ed. 2, Philadelphia, Saunders, 1949 p. 274. 3. Winsor, T., et al.: Amer. J. Med. Sciences 239:594, May 1960. 4. Eisenberg, S.: ibid, July 1960.

Literature giving indications, dosage, precautions, etc. available on request.

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The Doctor's Library

Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

MODERN OCCUPATIONAL MEDICINE. Editors: A. J. Fleming, M.Sc., M.D., F.A.C.P., Medical Director, E. I. du Pont de Nemours & Company and C. A. D'Alonzo, M.D., F.A.C.P., Assistant Medical Director, Medical Division, E. I. du Pont de Nemours & Company. Associate Editor: J. A. Zapp, Ph.D., Director, Haskell Laboratory for Toxicology and Industrial Medicine, E. I. du Pont de Nemours & Company, 66 illustrations; 1 color plate. Second Edition—Thoroughly Revised. Philadelphia: Lea & Febiger, 1960. Price, $12.00.

This is the second edition of a well-written book edited by members of the Medical Department of the du Pont Company. The book is presented with the purpose of providing a better understanding of the principles and methods of industrial preventive medicine. In addition to the usual occupational diseases, there is a section devoted to chest diseases and to emotional and mental illness seen by the industrial physician, with suggestions on how the industrial physician may deal with such employes. Plant safety programs are discussed with a new approach to safety education. The section on Biostatistics as a means of facilitating research in the genesis and history of degenerative diseases, is included.

This is a fairly up-to-date book and is highly recommended for those interested in industrial medicine. The section on Toxicology is particularly good and that on Occupational Chest Diseases is most informative and well illustrated.

R.W.B.

MEDICAL-SURGICAL NURSING. Kathleen Newton Shafer, R.N., M.A. Formerly Associate professor in Out-Patient Nursing, the Cornell University—New York Hospital School of Nursing, New York, N. Y.; formerly Assistant Consultant in Orthopedic Nursing, the National League for Nursing Education; formerly Instructor in Medical Nursing and Instructor in Surgical Nursing, the Cornell University—New York Hospital School of Nursing, New York, N. Y. Co-authors: Janet R. Sawyer, R.N., A.M., Instructor, School of Education, Department of Nurse Education, New York University, New York, N. Y. and Audrey M. McCluskey, R.N., M.A., Associate Professor in Nursing, the Cornell University—New York Hospital School of Nursing, New York, N. Y. Second Edition with 141 illustrations. St. Louis: The C. V. Mosby Company, 1961. Price, $8.75.

This is an advanced textbook for the student nurse or nurse practitioner for study and reference. Combining the medical and surgical aspects of nursing care is an intriguing accomplishment. This approach identifies the nursing needs

(Continued on Page 958)

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(Continued from Page 956)

of the patient who often moves from medical care to surgical intervention. This prevents needless duplication in referring to two texts and results in a more intelligible understanding of total-patient care.

Throughout, the authors have pin-pointed and stressed nursing care and have included only that amount of medical content necessary to identify the patient's needs. Subject matter is cross-indexed to facilitate location. Each chapter is prefaced by study questions to aid the student in study and is followed by a comprehensive bibliography for further pursuit of topics of interest. The authors have presented the material in an easy to read, perspicuous style.

Miss Shafer and co-authors have identified the new trends in nursing care and the resultant new responsibilities facing the nurse. In this second edition they have recognized the high incidences of injuries and have included a chapter on the nurse's role in accidents, emergencies, and disasters. Other important new sections that are included, discuss the problem of the aged, chronic illness, fluid and electrolyte balance, open-heart surgery, refrigeration, anesthesia and hypothermia, electric pacemaker, mouth-to-mouth resuscitation, use of radiation, and radioisotopes.

Older nursing procedures and problems are re-examined and new principles and techniques in handling them are identified.

J.A.J.

CIBA FOUNDATION COLLOQUIA ON ENDOCRINOLOGY. Volume 13 Human Pituitary Hormones. In Honor of Professor B. A. Houssay, For. Mem. R.S. Editors for the Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Cecilia M. O'Connor, B.Sc. 86 illustrations. Boston: Little, Brown and Company, 1960. Price, $9.50.

This is a report of a symposium on the anterior pituitary hormone and its effect on men and animals. This symposium, under sponsorship of Ciba Foundation was arranged in honor of Professor B. A. Houssay of Argentina, and took place in Buenos Aires. The papers and discussion by thirty-two international authorities will be of interest to those engaged in endocrine research.

R.W.B.

THE ROLE OF THE PHYSICIAN IN ENVIRONMENTAL PEDIATRICS. By Carl C. Fischer, M.D., Professor and Head of the Department of Pediatrics, Hahnemann Medical College and Hospital; Director of the Health Service, Girard College, Philadelphia, Pa. New York: Landsberger Medical Books, Inc., 1961. Price, $5.50.

In his small book of 100 pages in large type, the author points out many areas in which the pediatrician should function in present-day pediatrics. For example, in adoption practices, school health, care of the handicapped, and adolescent problems, the author explains the newer role of the pediatrician.

(Continued on Page 960)

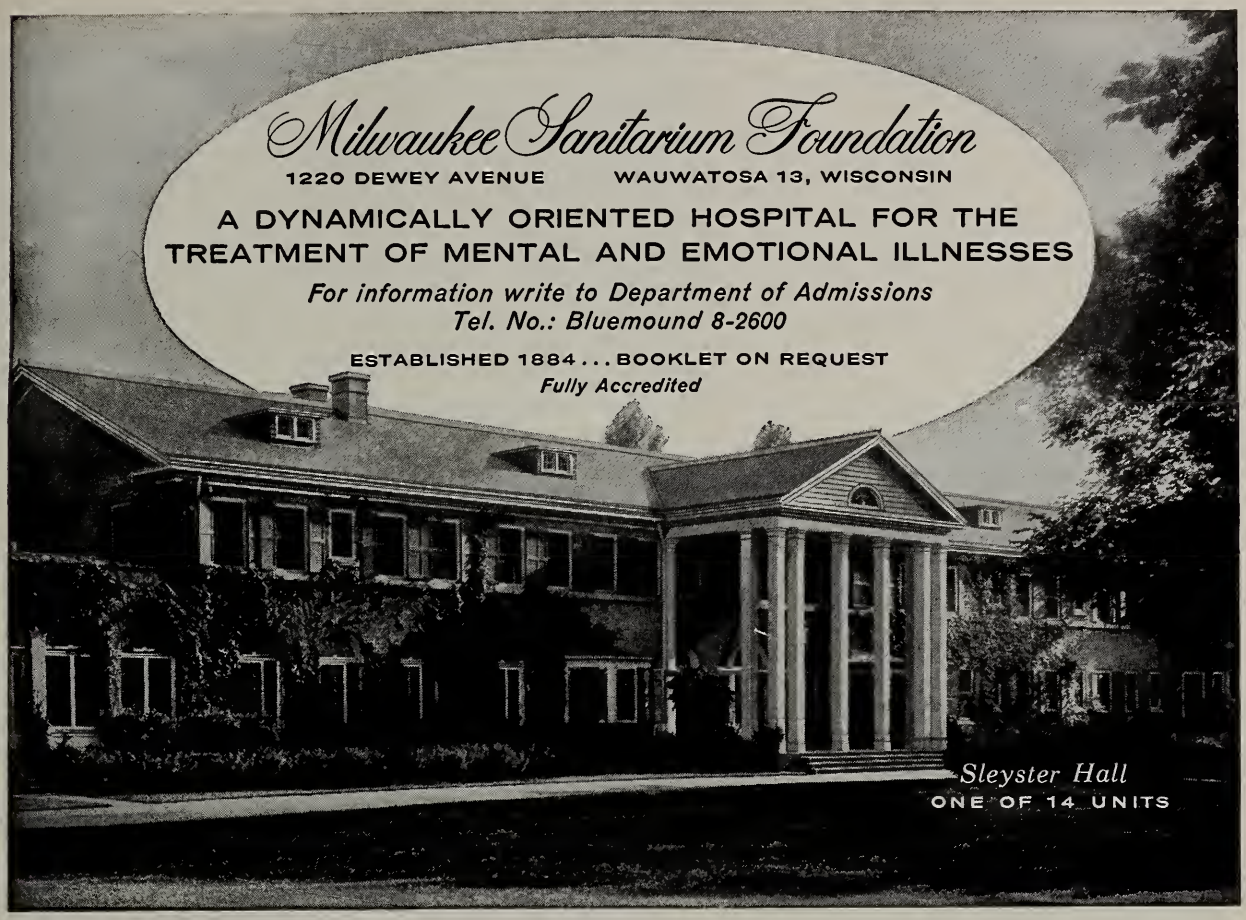


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(Continued from Page 958)

The book is a nice orientation for pediatric trainees, pediatricians and generalists. It tells of many important functions in child care programs, programs that many of us would hope to work at more strenuously.

F.J.M.

REVIEW OF MEDICAL MICROBIOLOGY. By Ernest Jawetz, Ph.D., M.D., Professor of Microbiology and Lecturer in Medicine and Pediatrics, University of California School of Medicine, San Francisco. Joseph L. Melnick, Ph.D., Professor of Virology and Epidemiology, Baylor University College of Medicine, Houston, Texas. Edward A. Adelberg, Ph.D., Associate Professor of Bacteriology and Chairman, Department of Bacteriology, University of California, Berkeley. Fourth Edition. Los Altos, California: Lange Medical Publications, 1960. Price, $5.00.

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This book has an excellent chapter on anti-microbial chemotherapy and this also discusses the side effects, toxicity, mode of action, and areas of absorption of most of the current antibiotics. The discussion concerning the pleuropneumonia-like organisms is well presented in a brief outline and the sections devoted to viruses are well illustrated and lucid. Many of the illustrations are based on recent electron microscopy studies, and are excellent. Even the diagram and text, explaining chick embryo techniques, should be of interest to any physician who might speak casually of such procedures but, in most instances, has no exact knowledge of the methods employed. There is an extensive table outlining the various laboratory diagnostic tests in viral diseases and it is of value to all those interested in diagnostic medicine. The portion devoted to infectious and serum hepatitis is current in thought and well worth reading; in the same vein, the evaluation of various agglutination tests is excellent, particularly the comment on the proper time to do heterophile studies in the cases of infectious mononucleosis. The proper timing of this procedure is not widely known.

There are a number of exotic diseases unknown in this country that are described at some length and do not contribute much, as far as the average American physician is concerned; but, on the other hand, there is a brief, but knowing, comment on such common, but often poorly understood diseases, such as Cat-scratch Fever. The book is recommended to those interested in recent developments in basic medical science.

A.A.H.

CIBA FOUNDATION COLLOQUIA ON AGING. Volume 5. The Lifespan of Animals. Editors for the Ciba Foundation G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Maeve O'Connor, B.A., With 58 Illustrations and Cumulative Index to volumes 1-5. Boston: Little, Brown & Company, 1960. Price, $9.50.

This is an interesting book that embodies an enormous volume of almost pure research in a brief space. It is the last of five similar books devoted to a colloquia on aging. The discussion of the development of arteriosclerosis in various birds is well illustrated and informative, but some portions are of interest only to those actuarially or mathematically inclined. The cause of death listed percentage-

(Continued on Page 962)

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*Ped. Clinics N.A., 8:225 (Feb.) 1961, W. B. Saunders, Phila.



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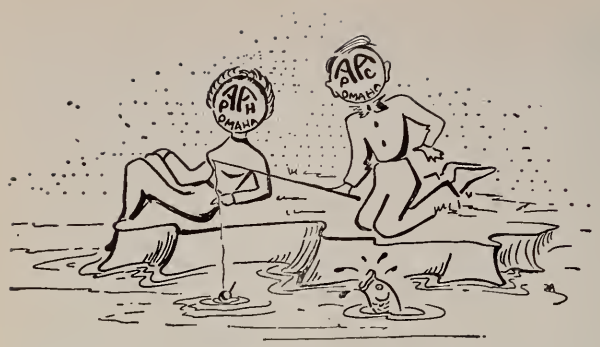
wise in the analysis of horse mortality should be of general interest and it is encouraging to note that Musca domestica, the common house fly, lives only an average of 17 days in the case of a male, but the female enjoys a mean life-span of 29 days, a trend duplicated in humans; in this instance, however, it was found that female longevity in the house fly was enhanced by the inclusion of whole powdered milk in the standard diet, but no such beneficial effect was obtained for the male.

Considerable data is included in the chapter on parental age effects in man. This is a good book but only of value to clinicians who have a casual interest in this field, or in geriatrics.

A.A.H.

INFORMATION, PLEASE! FOR WOMEN ONLY. Incorporating The Dunhill Chart by Alfred Dreyfus II. New York, Washington, Hollywood: Vantage Press, 1961. Price, $7.50.

This book, as its title suggests, gives much information "for women only." The main feature of the book is the Dunhill Chart, which presents at a glance what times during the menstrual period a woman is, or is not, likely to become pregnant. It also contains a schedule to help the mother-to-be understand the changes in her condition until her baby is born. In addition to this chart, much information is given on female hygiene and sexual disorders. Venereal disease is discussed, as are disorders of menstruation, sexual maladjustments, motherhood, pregnancy, and how the baby grows. There is much valuable information in this book.



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MICHIGAN the Journal
STATE MEDICAL SOCIETY
Volume 60 Number 8
August, 1961

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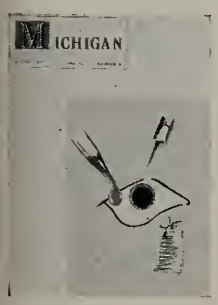
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THE COVER

THE JOURNAL, this month, contains special articles about Ophthalmology. The cover art ties in with both an article and an editorial about contact lenses.

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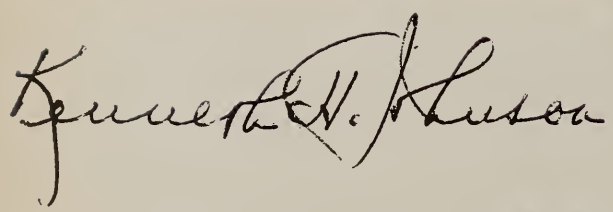
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President's Page

HI, YOUNG FELLOW!





President
Michigan State Medical Society

I use that salutation for a distinct purpose. Regardless of your age, I do consider you a "young fellow."

I would explain, by quoting some recent research:

> "Older persons tend to respond to inner rather than outer stimuli, to withdraw emotional investments, to give up self-assertiveness, and to avoid rather than to embrace challenge."

Now, do you agree that you are a "young fellow," ready to deal with complicated, challenging or conflictful situations? You have a tendency to perceive vigorous and assertive activity, don't you? And you have what the study calls lots of "ego energy," right?

> (You may want to read about this interesting research project reported by J. L. Rosen, and B. L. Newgarten in "Journal of Gerontology," Vol. 15, No. 1)

Well, to get to the point. As a "young person" with energy, determination and spirit, you will want to attend the 1961 MSMS Annual Session at Grand Rapids, September 24-29. You will have opportunities there for new experiences, new knowledge, new friendships. There will be challenges—but remember the research study has proven that young men seek such activities.

So, "young fellow," we'll see you in Grand Rapids!

MSMS Says King Bill "Totally Unnecessary"



Washington, D. C.—The House Ways and Means Committee heard a Michigan contention that the King Bill is unnecessary and that the Kerr-Mills Law is meeting the health care needs of the aged.

"The Michigan State Medical Society commends the House Ways and Means Committee for its rejection last year of the social security approach and its approval instead of the Kerr-Mills program of federal-state grants to aid those older citizens who may need assistance in meeting their health care costs."

That statement was made July 27 before the House Committee's hearing on the King Bill (H.R. 4222) by Otto K. Engelke, M.D., president-elect of the Michigan State Medical Society.

* * *

"MICHIGAN HAS DEVELOPED and is improving its Medical Aid for the Aged program under the Mills Law. The Mills Law will do the job," stressed Dr. Engelke of Ann Arbor.

"The Michigan State Medical Society actively endorsed the original Michigan Medical Aid to the Aged program and wholeheartedly supported the MAA liberalization approved this spring by the Michigan Legislature and Governor," Dr. Engelke reported. He observed, "The Michigan application of the Mills Law and other present programs providing medical aid to the aged are designed to give maximum help to those who need it."

Dr. Engelke requested that the House Committee refuse to recommend the King Bill. "The King Bill is totally unnecessary and can lead only to greater problems than now exist," he said.

* * *

"MICHIGAN PHYSICIANS FIRMLY believe that Congress should again reject the social security approach to providing health care for the aged," said Dr. Engelke, a teacher in the University of Michigan school of public health and the health officer of Washtenaw County.

"Michigan doctors are convinced that the King approach is socialized or nationalized medicine, and that stopping the nationalization of medicine once it has started is like unscrambling eggs."

The 10-point positive program of the Michigan State Medical Society to better serve Michigan residents was detailed by Doctor Engelke before the House Committee.

The speaker stressed that "Michigan doctors of medicine have long been active in forming solutions to the problem which the Committee faces. We shall continue to provide the world's highest quality of medical care to all of Michigan's residents and shall assist all those who need help in meeting the cost of medical care."

The Michigan State Medical Society was one of seven state medical associations that testified against the King Bill, along with the American Medical Association and many national, civic, farm and business organizations.

Hospital Features Beaumont Plaque

The newest development in the Beaumont lore is the presentation of a bas-relief plaque of William Beaumont, M.D., to the Beaumont Hospital by the Oakland County Medical Society. And thanks to the

generosity of friends located in Oakland County, a copy will be made for the Beaumont memorial at Mackinac Island.

The artist, Marshall Fredericks, depicts the strong character and rugged individuality of the doctor. He also chose to show Doctor Beaumont in civilian dress rather than in uniform. The plaque credits the doctor as "Pioneer in Gastric Physiology."

In the article about the plaque in the June issue of the Oakland County Medical Society Bulletin, writer Charles Paul Barker, M.D., pointed out "The work of Dr. Beaumont becomes all the more remarkable when one remembers that such vital medical discoveries resulted from the work of an individual doctor with an individual patient. Viewed in this light, we see the bond between Dr. Beaumont and his patient, Alexis St. Martin, as a magnificent tribute to the unencumbered doctor-patient relationship."

Council Voices Thanks For Checks, Flowers

Two checks in the amount of $100 each have been accepted by The MSMS Council for the new MSMS headquarters from the Clinton County Medical Society and the Oakland County Medical Society.

Most appreciative of the contributions, The Council ordered that recognition be given in THE JOURNAL.

The Council asked also that the names of the persons and organizations presenting flowers for the dedication program be printed.

Beautiful flowers for the dedication were received from the following:

Calhoun County Medical Society, Genesee County Medical Society, Kalamazoo Academy of Medicine, Mecosta-Osceola-Lake County Medical Society, St. Joseph County Medical Society, Washtenaw County Medical Society;

Michigan State Board of Registration in Medicine, Michigan State Grange, Michigan State Podiatry Assoication, State Bar of Michigan;

Los Angeles Dental Society, Oklahoma State Medical Association, State Medical Society of Wisconsin;

Bruce Publishing Company, St. Paul, Minnesota, James Gerity, Jr., Adrian, Michigan, Mead Johnson & Company, Evansville, Indiana;

Belen's Flowers, Lansing, College Drug, East Lansing, Granger Brothers Construction Company, Lansing, Hasselbring Company, Lansing;

Norm Kesel, Florist, East Lansing, Lansing General Hospital, Michigan National Bank, Lansing, W. A. Pomeroy and Associates, Inc., Lansing, Silver Lead Paint Company, Lansing, The Michigan Company, Lansing;

From Dr. Johnson's office personnel—Mrs. Florence Morey, Mrs. Irita Nimphie, Mrs. Vivian Worthington.

Pick Kalamazoo Doctor As Biddle Lecturer

Homer H. Stryker, M.D., Kalamazoo, has been selected to present the Biddle Lecture at the 1961 MSMS Annual Session, at the State Society Dinner Dance, September 28. Highly recommended by many as a speaker, Doctor Stryker will entertain with his dead-pan, witty comments.

This will be the first time that the Biddle Lecture has been presented at the Dinner Dance. The program for the Dinner Dance was altered last year and is currently undergoing further experimentation.

Doctor Stryker reports that his address will be entitled, "So You Want To Go Into Business."

* * *

A NATIVE OF Michigan, he received his medical education and postgraduate training at the University of Michigan and the University Hospital. He practices orthopedic surgery in Kalamazoo and is chief of orthopedic service at the Borgess Hospital of that city.

His hobby shop in the basement of the hospital has grown into the Orthopedic Frame Company with 65 employees. Doctor Stryker has designed several pieces of orthopedic and hospital equipment.

* * *

THE MSMS ANNUAL BANQUET also will highlight three acts of professional entertainment of top-notch calibre. Coming from Chicago to perform and amuse will be Frank Ross, internationally-known comedian who has appeared on the Ed Sullivan and Jack Paar shows; the Carvelares, a fast comedy act, and also Carl and Arlene, pantomime artists.

MICHIGAN MEDICAL MEETINGS AND CLINIC DAYS

Sept. 24-26	MSMS House of Delegates	Pantlind Hotel, Grand Rapids
Sept. 27-28	Michigan State Medical Assistants Society	Occidental Hotel, Muskegon
Sept. 27-28	Woman's Auxiliary to MSMS	Pantlind Hotel, Grand Rapids
Sept. 27-29	MSMS Annual Scientific Session	Pantlind Hotel and Civic Center, Grand Rapids
Oct. 5	Gastroenterology Clinical Conference	Bronson Hospital, Kalamazoo
Oct. 19	Calhoun County Clinic Day	Battle Creek
Oct. 20-21	U-M Doctors' Day	Ann Arbor

"State Society Dinner Dance" Thursday, September 28, 1961 Pantlind Hotel, Grand Rapids



Homer H. Stryker, M.D

A highlight of the evening will be a witty address by Homer H. Stryker, M.D., Kalamazoo, who is known for his dead-pan humor. It will be a full evening of fun—preprandials, an excellent dinner, an entertaining program, dancing, and a stellar floor show. Food, Fun and Fellowship.

Plan Now to Enjoy This Delightful Event

ALL MSMS members and their ladies are invited to the "State Society Dinner Dance" for an evening of fun and merriment. Also attending this colorful social event will be the Annual Session exhibitors. The tickets will be limited, so circle your calendar now. An advance reservation form will be mailed to you soon.

Seek Entries in Annual Session Art Exhibit

Plans have been completed for the Annual Session Art Exhibit to be conducted by the Woman's Auxiliary to MSMS for members of both the Auxiliary and MSMS.

The entry procedure is an easy one—all that interested members must do is to take their art work with them to Grand Rapids for the Annual Session and register it then with the Auxiliary committee before noon, September 25.

The following entry regulations are outlined by Mrs. Robert W. Emerick, of Fremont, chairman for the interesting project:

* * *

ALL WORK MUST BE completely original and entirely by the artist submitting it. Each entrant is limited to four entries which may be in one class or any combination of classes.

Oil paintings must be suitably framed. Watercolors, drawings and prints must be matted and/or framed. All framed entries must be equipped with eyelets and wire suitable for hanging. Entries must be brought in by hand. Usual care will be exercised in handling all entries, but we cannot assume liability for accidents in handling, breakage, or loss by theft. Entries will not be insured. Insurance, if desired, should be carried by the exhibitor.

* * *

ENTRIES WILL BE RECEIVED Sunday, September 24, from 1:30-4:30 p.m., and Monday, September 25, from 9-12 noon, on the mezzanine of the Pantlind Hotel.

The action of the Juror will be considered final in both entries accepted and award designation. Juror of Selection and Award: Richard Yonkers, Director, Hackley Art Gallery, Muskegon. The exhibit sponsors assume the privilege of photographing for publicity any work submitted.

Artist must firmly attach to the back of each entry a label giving the following information:

Name
Address
City
Title
Medium

Awards:

Class I. Painting, including oil, encaustic lacquer, polymer, etc.

Class II. Painting, including watercolor, casein, tempera, gouache.

Class III. Sculpture, including wood, stone, ceramic, metal.

Class IV. Ceramics.

Class V. Drawing and graphic art, including all print techniques.

Class VI. Three dimensional design: weaving, jewelry, metal work, woodcarving.

The exhibit will open Tuesday, September 25, at 11 a.m.

* * *

ALL ENTRIES MUST REMAIN on display until 12 noon, Thursday, September 28. They will be stored at owner's expense if not picked up following the close of the Annual Session. Any additional information may be secured from the chairman of the Art Exhibit: Mrs. Robert W. Emerick, 3947 Shorewood Drive, Fremont.

Journal Article Popular

The New York State Department of Social Welfare's Commission for the Blind reported recently to MSMS that an article reprinted from THE JOURNAL MSMS has proven very popular. The request to further reproduce the article by R. T. Blackhurst, M.D., Midland, which appeared in 1957 in THE JOURNAL MSMS, was sought because—"We are receiving a continuing flow of requests for this article." The New York agency proposes to distribute the article to parents through schools and nursing groups.

Fight on Quacks

Question: What does the AMA consider as its second biggest accomplishment to date?

Answer: Its relentless fight against quacks and charlatans.

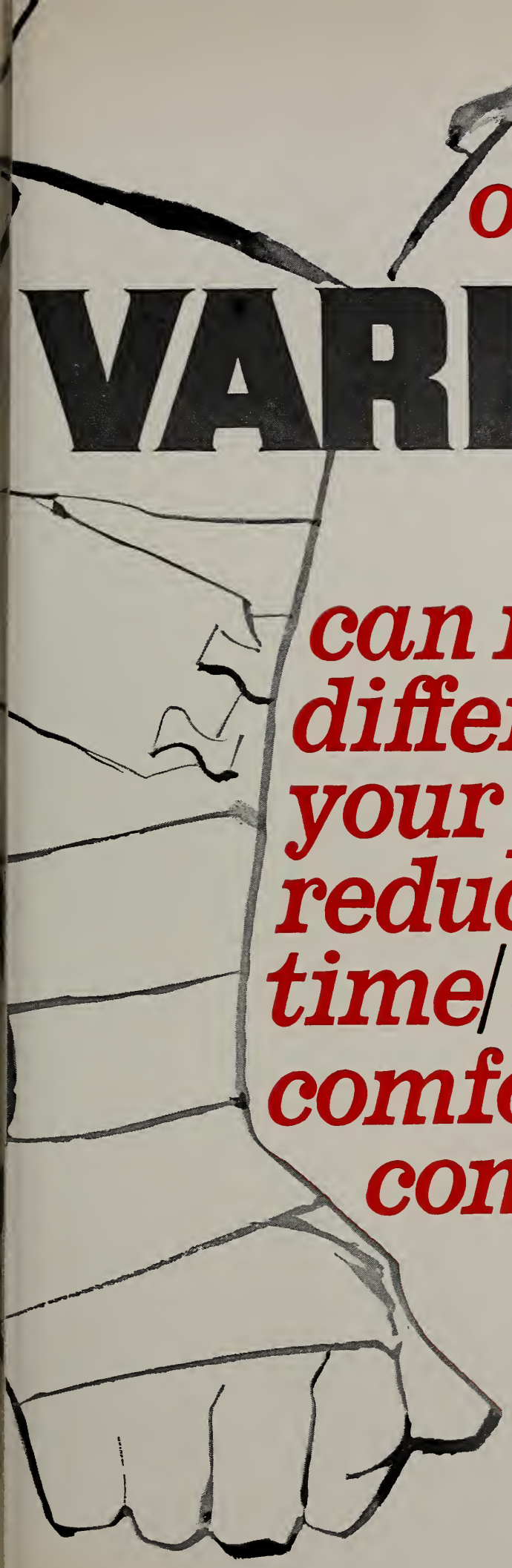
* * *

The men of vision, who founded the AMA, centered their attention on the brisk traffic in secret remedies.

To this day, the AMA, through its Bureau of Investigation, takes a lively interest in running down pernicious nostrums and worthless patent medicines for which the public each year squanders millions. It was this Bureau, founded in 1906, that gave the AMA stature with the public.

The Bureau conducts original investigations. It receives information from federal sources such as the Food and Drug Administration, Post Office Department, and Federal Trade Commission.

The Bureau, which receives thousands of inquiries every year, does not itself prosecute quacks, but it frequently provides the necessary evidence that leads to conviction.



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HIGHLIGHTS of The Council
Meeting of June 3, 1961

- MSMS headquarters. O. B. McGillicuddy, M.D., Chairman of the Finance Committee, reported on MSMS building boiler insurance and on contract for maintenance of Honeywell controls; also that the former MSMS building at 606 Townsend in Lansing has been sold for cash.
 A house committee composed of staff personnel, to superintend details of maintenance, has been appointed with K. H. Johnson, M.D., as advisor.
- Committee reports. The following were given consideration: Mental Health Committee, meetings of March 2 and of April 26; Tuberculosis Control Committee, March 1; Disaster Medical Care Committee, March 7; Geriatrics Committee, March 10; Occupational Medicine Committee, March 10 and May 12; Legal Affairs Committee, March 16; Medical Care Insurance Committee, April 5 and May 10; Committee on Insurance, April 12; Educational Liaison Committee, April 24; Rheumatic Fever Control Committee, April 26; Medical Care Study Committee, May 3 and May 24 (considered the U-M Study of Hospital and Medical Economics—the McNerney Report); Maternal Health Committee, May 11; Vocational Rehabilitation Committee, May 11; Public Health Committee, May 17; Committee to Study Problems of Emergency Care in Hospitals, May 23; Advisory Committee to Michigan State Medical Assistants Society, March 9; Permanent Conference Committee, May 24; and the Finance Committee of The Council, June 3.
- Harold F. Falls, M.D., was appointed MSMS representative to the Governor's Commission on Prepaid Hospital Plans, with O. K. Engelke, M.D., of Ann Arbor as alternate.
- Committees for the 1962 Michigan Clinical Institute, appointed by Council Chairman H. J. Meier, M.D., of Coldwater, were presented to The Council and approved.
- Development of an MSMS statement of policy re podiatry was discussed; when drafted, this statement is to be sent to the orthopeadic societies of Michigan for perusal before final presentation to the MSMS Council.
- Dedication of new building, June 4. President Johnson reviewed plans for the ceremonies in connection with the dedication at which W. S. Jones, M.D., of Menominee is to be General Chairman.
- Report on annual visit to Washington, D. C., to interview U. S. Senators and Congressmen from Michigan was accepted with thanks.
- Report of Michigan Health Conference at Flint, May 23-25 was reported by K. H. Johnson, M.D.; The Council placed on its minutes a vote of appreciation to the Michigan Health Council in recognition of its fine work, especially to Conference Chairman H. A. Towsley, M.D., of Ann Arbor.
- O. K. Engelke, M.D., MSMS President-Elect, presented a list of MSMS committee appointments for the Society year 1961-1962 which was approved. President-Elect Engelke also reported on the AMA Workshop on Home Care, held in Chicago, May 24-26, which report was received with thanks.
- The offer of Parke-Davis & Co. of Detroit to display its 30 paintings on "The History of Medicine" at the MSMS Annual Session in Grand Rapids was accepted with gratitude.
- Speaker J. J. Lightbody, M.D., of Detroit reported on meetings of House of Delegates committees and announced the appointment of the new Ways and Means Reference Committee of The House, to be Chaired by Arthur W. Strom, M.D., of Hillsdale; he also reported on the four regional Legislative Conferences, authorized by the House of Delegates at its special session of April 16; Doctor Lightbody also stated that a reception in the new MSMS headquarters building in East Lansing was being arranged for Delegates and Alternate Delegates on Sunday, September 24 between 1:00 and 5:00 p.m.
- Legal Counsel Lester P. Dodd presented an opinion re validity of a clause in a component society's bylaws making it mandatory that any member missing more than one-third of its meetings without a legitimate excuse be dropped from membership; an opinion on a matter of ethics; a memorandum on advantages and disadvantages of incorporation of county medical societies; an opinion on potential liability of physicians serving on medical advisory boards for the medical re-evaluation of unfit automobile drivers. Legal Counsel has been studying the possibilities of organization of Kintner-type associations in Michigan through legislation or otherwise; he presented an opinion with respect to free choice of physician under Michigan's Compensation Act.
- Public Relations Counsel's report included information on state and federal legislation; the MSU Career Carnival of October 9-10 in East Lansing in which MSMS participation was approved by The Council; and information re the Constitutional Convention.
- Matters of mutual interest were discussed with State Health Commissioner A. E. Heustis, M.D., including (a) out-patient services in Howell; (b) financing of state tuberculosis hospitals; (c) deletion of Michigan Department of Health services; and (d) Council of Health members.

Communications Potentialities Of the Printed Word

By Jean Worth, *Escanaba Daily Press*

(Second of several installments of a paper presented before the 1961 MSMS County Secretaries-Public Relations Seminar. The first part of the paper appeared in the June issue)

The nearly 3 billion people on the globe speak about 1,500 different languages, but fortunately our immediate problem isn't so large. Here in America English will do for internal purposes and this cozy fact tends to oversimplify our need, so that it is believed that if a problem and solution are presented nationally in saturation manner in the newspapers and magazines and on radio and TV, it will be solved. The Republicans know that this is not necessarily so.

What is the hope of the American Medical Association in public exchange with our free spending Congressmen on the inclusion of medical care of the aged under Social Security? Public opinion will decide this issue.

In a book on this subject and with this very name, "Public Opinion," Walter Lippman suggests that the angels are going to be on the side of the Congressmen in this one. He says "The practice of appealing to the public on all sorts of matters means always a desire to escape criticism from those who know, by enlisting a large majority which had had no chance to know.

"News and truth," suggests Lippman, "are not the same thing. The function of news is to signalize an event and the function of truth is to bring to light the hidden facts and set them in relation with each other and make a picture of reality on which men can act. Only in a small part of the field of human interest do news and truth coincide.

"When we expect the press to supply the truth spontaneously we misunderstand the limited nature of news and the complexity of society; we over-estimate our own endurance and the public spirit and all-around competence. We suppose an appetite for uninteresting truths which is not discovered by any honest analysis of our own tastes.

"If newspapers are to be charged with the duty of translating the whole public life of mankind, so that every adult can arrive at an opinion on every moot topic, they fail; they are bound to fail; in any future one can conceive they will continue to fail. It is impossible to assume that a world carried on by division of labor and distribution of authority can be governed by universal actions in the whole population.

"The troubles of the press, like the troubles of representative government and like the troubles of industry, go back to a common source, to the failure of a self-governing people to transcend their casual experience and their prejudices by inventing, creating and organizing a machinery of knowledge.

"It is because they are compelled to act without a reliable picture of the world that governments, schools, newspapers and churches make such small headway against the more obvious failings of democracy, against violent prejudice, apathy, preference for the

curious trivial as against the dull important. This is a primary defect of popular government, a defect inherent in traditions, and all its other defects can, I believe, be traced to this one."

* * *

Lippman believes that only if problems are processed can the modern citizen cope with them intelligently. He says that on many subjects of great public importance the threads of memory and emotion are in a snarl and that "the same word will connote any number of different ideas."

* * *

More than 600,000 English words have been put together, each a symbol for a fact of meaning and—unfortunately—often for two or ten. We're told by the semanticists that modern man can convey small differences of meaning never possible to early man. This is an exactitude, however, which has brought with it tremendous problems of muddy symbolism that strongly affect modern communications.

In the use of words in communication we should be concerned with reaction to the word. People do not react to the dictionary explanation of the meaning of a word by means of other words, but to what the word symbolizes for them individually.

All of us tend to think that we use words the right way and that people who use the same words in other ways are dumb or crooked. Semanticist Samuel Hayakawa illustrates this point by citing that when the Russians use the word "democracy" for their own purposes in a way that outrages our definition of it we accuse them of propaganda, while they say our use is hypocrisy.

Alfred Korzybski, the founder of general semantics, says that persons who fuse off mentally in contact with such loaded words as "socialized medicine," "creeping socialism," "tax the rich," "Republican," "Democrat," "Catholic," "Jewish," "Roosevelt," "Kennedy," "Negro," etc., have short circuits. He calls them "identification reactions."

He uses "identification" in a special way to mean that such persons give such a fixed identity to such words that they give identical response to all occurrences of the word under all circumstances, no matter how differing. This is the situation when Democrats or Republicans react to the entire political campaign in terms of party labels only.

Korzybski believed that "identification reaction" described most cases of semantic malfunctioning. If we assume that everything has a "right name" and that the right name names the essence of what is named, we are apt to have reaction patterns that are subject to premature and often inappropriate responses. We're apt to react to names as though they give insight into persons or things.

To realize the difference between words and what they stand for helps us understand the differences and similarities in the world and is absolutely necessary for scientific thinking, as well as for sane thinking.

Berrien Society Explains Medical Career Opportunities

The Berrien County Medical Society recently sponsored a career program for high school youths from the area. August F. Bliesmer, M.D., St. Joseph, instigator, reports that they invited the juniors and seniors of our five area high schools, public and parochial, who were, or might be, interested in medicine as a career, to a meeting in the library of the St. Joseph High School, with 50 in attendance.

Six local doctors served on a panel. The film "I Am a Doctor" was shown, and material prepared by the AMA was distributed. The evening concluded with cokes, coffee, and sweet rolls. The book, "Admission Requirements of American Medical Colleges," was helpful in answering questions pertaining to admissions and costs.

* * *

U. S. Census Bureau reports size of average American family increased between 1950 and 1959 from 3.54 persons to 3.66 Southern families, with 3.81 persons, were larger than those in any other region.

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An Evaluation of the Etiologic Survey In Chorioretinitis

Conrad L. Giles M.D.
Alan Lewis, M.D.

Ann Arbor, Michigan

CLINICAL 1001



ALTHOUGH chorioretinitis is primarily diagnosed and treated by the ophthalmologist, there is virtually no segment of the medical community which at some time is not called upon to evaluate patients exhibiting the disease.

As the term implies, chorioretinitis, or posterior uveitis, is an inflammation of the choroid and retina. The diagnosis is made on the basis of an ophthalmoscopic examination and presents little difficulty.

The ophthalmoscopic picture of chorioretinitis is variable. The inflammatory process can result in great exudation with clouding of the vitreous cavity and obscuration of retinal detail. Often, however, the exudation is mild and detailed areas of exudate, which appear as white cloudy patches with irregular borders about the size of the optic disc, can be seen surrounded by the normal retina (Fig. 1). Less frequently, the lesion may be cystic with a surrounding collarette of hemorrhage in or near the macula or periphery, and they may be multiple or single (Fig. 2). Those lesions occurring centrally are associated with a loss of central visual acuity, often acute in onset whereas when the process is more peripherally located, mild blurring is the patient's primary complaint.

Because scarring of the involved area is a frequent end result of chorioretinitis, centrally located lesions pose a definite threat to the preservation of useful vision (Figs. 3 and 4). It is for this reason that the institution of specific therapeutic measures is so important.

The etiology, however, is usually obscure, and therapy is most often based on indirect clinical and laboratory evidence of causative agents. This is necessary because culture and biopsy, the usual methods of isolation of organisms, are not available to the clinician treating conditions affecting the posterior segment of the eye.

As a result of this necessarily indirect aprpoach to diagnosis, the list of possible etiologic factors is long (Table I), the evidence on which each is based often tenuous, and the therapeutic regimens employed are legion.[1]

From the University of Michigan Medical Center, Ann Arbor, Michigan.

Since 15 per cent of all known blindness in this country is a result of inflammatory conditions of the eye, it behooves the ophthalmologist to periodically evaluate the etiologic survey methods he employs in an attempt to learn which portion of his work-up is valuable and which portion is not.

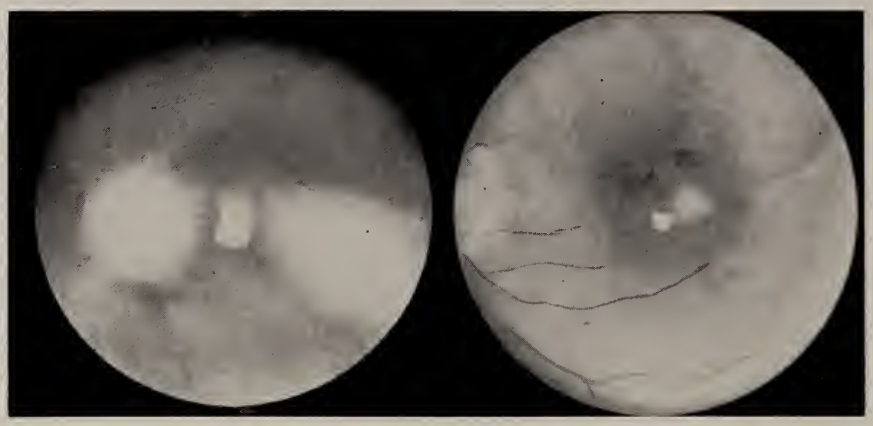


Fig. 1. Acute chorioretinitis with exudative lesion present temporal to the optic nerve and located in the macula. The overlying vitreous is hazy as a result of inflammatory products.

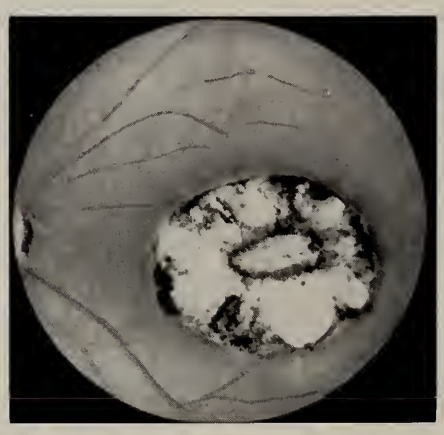


Fig. 3. A fundus photograph of healed, inactive macular chorioretinitis. This patient was legally blind in this eye and was only able to count fingers at a distance of 2 feet.



Fig. 4. This is a drawing of healed, inactive, central and peripheral chorioretinitis with an unusually large amount of retinal destruction.

This report deals with the etiological survey in 100 consecutive cases of chorioretinitis seen in the University of Michigan Medical Center between February, 1959, and July, 1960.

Review of Literature

Since 1850 when major interest was first focused on chorioretinitis many etiologies have passed in and out of fashion.

In the middle 1800's syphilis, tuberculosis and "rheumatism" were most often implicated as causes of uveitis. These entities remained as prime considerations until 1900 when the concept of focus of infection supplanted these entities as the most favored etiologic diagnosis. For the first quarter of this century focus of infection and syphilis equally shared the etiologic limelight, but with the increased utilization of serologic technique, it slowly became apparent that leutic infection was only infrequently associated with uveitis.

The use of the tuberculin skin test increased the emphasis of clinicians on tuberculosis as a major cause of chorioretinitis after 1925. The most important recent contribution to the search for etiologies in chorioretinitis was made by Wilder in 1952 when she discovered *Toxoplasma gondii* in the necrotic chorio-

retinal lesions in adult eyes which had previously been diagnosed as typical tuberculosis but in which tubercle bacilli could not be found. It is now generally recognized that not only is toxoplasmosis a proven cause of uveitis, but that it is one of the most important causes.[2]

In 1941 the first in a series of reports on etiologic surveys from the Wilmer Institute was published. Tables II, III and IV contain the data from the Wilmer studies[2-4] and are included for interest and comparison with this report.

TABLE I. ETIOLOGIC FACTORS

Chorioretinitis
- Protozoal
 - Toxoplasmosis
- Bacterial
 - Tuberculosis
 - Syphilis
 - Brucellosis
- Fungal
 - Histoplasmosis
- Parasitic
 - Cysticercus
 - Toxocara
 - Filaria

Generalized Uveitis
- Tuberculosis
- Sympathetic Ophthalmia
- Vogt—Koyanagi—Harada
- Behcet's
- Pyogenic Endophthalmitis
- Sarcoidosis

A series very similar to this report was published by Schlaegal[5] in 1958 (Table V). This author concludes that "the diagnosis made will depend on the diagnostic acumen, battery of tests employed, the individual worker's opinion as to the relative importance of various etiologic agents, and rigidity of criteria for making of a diagnosis."

TABLE II. WILMER INSTITUTE ETIOLOGIC SURVEY (GUTON, WOODS) (1925-1939) 562 Cases

Etiology	Per Cent With Definite Diagnosis	Per Cent With Presumptive Diagnosis	Total
Tuberculosis	23.5	26.1	49.7
Lues	8.0	2.5	10.5
Sarcoid	0.5	0.0	6.5
Brucella	0.2	0.2	0.4
Foci of infection	5.5	20.6	26.1
Gonorrhea	1.8	2.8	4.6
Nongranulomatous systemic disease	2.5	3.4	5.9
Metabolic disease	0.0	0.5	0.5
Miscellaneous	1.4	0.4	1.8

In another recent report, Perkins[6] presents a series of 653 cases of uveitis where a 4.4 per cent incidence of association with ankylosing spondylitis and a 2.1 per cent incidence with sarcoidosis was found. In this same series, 50 per cent of 106 cases with chorioretinitis showed a positive Dye test for toxoplasmosis.

The English workers in this field are now emphasising the importance of the association of prostatitis with chorioretinitis. This work has excited little interest in the United States, but may be of greater importance than is now realized.

Thus it would appear that a full cycle has been reached and the influence of foci of infection on chorioretinitis may again be coming into the etiologic limelight.

TABLE III. WILMER INSTITUTE ETIOLOGIC SURVEY (WOODS) 157 Cases

Etiology	Per Cent
Tuberculosis	52
Lues	17
Sarcoid	10
Brucella	10
Toxoplasmosis	0
Histoplasmosis	0
Miscellaneous	5
Undetermined	6

TABLE IV. WILMER INSTITUTE ETIOLOGIC SURVEY (WOODS) (1950-1960) 432 Cases

Etiology	Per Cent
Acquired toxoplasmosis	30.9
Tuberculosis	27.0
Toxoplasmosis or tuberculosis	6.7
Lues	4.6
Sarcoid	4.4
Brucellosis	4.9
Histoplasmosis	3.9
Miscellaneous	1.4
Undetermined	15.5

Method of Study

The case records of 100 consecutive posterior uveitis patients investigated at the University of Michigan Medical Center between February, 1959, and July, 1960, were examined.

All of these patients, in addition to a detailed ophthalmologic examination, received a diagnostic survey which routinely included the following tests: (1) Chest microfilm, (2) Serological test for syphilis (Kahn test), (3) Urine sugar and albumin, (4) Tuberculin (OT 1:4000) skin test, (5) Histoplasmosis skin test, (6) Coccidiodomycosis skin test, (7) Blastomycosis skin test, (8) Toxoplasmosis skin test and control, (9) Frei skin test and control, (10) Complement fixation studies to histoplasmosis, coccidiodomycosis and blastomycosis.

In addition, the majority of patients received Brucella agglutination determinations. The Sabin-Feldman titer (toxoplasmosis) was drawn at the discretion of the examining physician.

TABLE V. ETIOLOGIC SURVEY (SCHLAEGAL) 100 Cases

Test Performed	Per Cent Positive Results
Positive OT skin tests	67
Positive histo skin tests	38
Positive toxo skin tests	58
Positive serology for lues	3
Brucella agglutinins	7
Urinalysis	Negative
Sabin-Feldman dye test 1:4 or greater	68
Chest x-ray	40
Consultations—not done	
Probable diagnosis	17

Consultation with the Departments of Urology, Internal Medicine, Oral Surgery, Otology and Gynecology were obtained in a large segment of this group of patients.

Result of Survey

Sex Incidence.—There were 58 males and 42 females in this series.

Age Incidence.—The youngest patient in the series was seven years of age; the oldest 69. The average age of onset of the disease was 35, in both the male and female groups.

Chest Microfilm.—The chest microfilm was negative in 76 cases and revealed some abnormality in 24 patients. An active disease process was not found in any of this latter group of patients.

Serologic Test for Syphilis, Urine Sugar and Albumin.—A positive Kahn test was not obtained in any patient and no patient exhibited either albuminuria or glycosuria in this series.

Skin Tests.—The results of skin testing are listed in Table VI. A scant majority of the patients exhibited a positive toxoplasmin skin test (54 per cent). No case demonstrated a positive skin test control and positive active antigen simultaneously in the toxoplasmin sensitive group. Thirty-two per cent of the patients exhibited a positive histoplasmin skin test, while only 25 per cent showed tuberculin hypersensitivity. Three per cent of the group were positive to coccidiodin antigen and one patient questionably demonstrated Frei test sensitivity.

Of particular significance is the fact that 32 patients had at least two positive skin tests.

Complement Fixation Studies.—The studies for histoplasmosis, coccidiodomycosis and blastomycosis complement fixation were entirely negative in 77 patients. Thirteen patients showed significant histoplasmosis titers. In four of this group concomitant titers were present to coccidiodomycosis and/or blastomycosis.

The serum in the remaining ten cases was anticomplementary.

All studies were obtained from the Public Health Service Laboratories in Chamblee, Georgia.

Brucella Agglutination.—Brucella agglutination levels were obtained in 83 cases. Three cases were positive. In repeat determinations, however, no patient exhibited a rising titer of Brucella agglutination.

TABLE VI. POSITIVE SKIN TESTS

Antigen	Number
Histoplasmin	32
Tuberculin	25
Coccidioidin	3
Blastomycin	0
Frei	?1
Toxoplasmin	54

Sabin-Feldman Dye Titers.—Sabin-Feldman Dye determinations were made in 43 of the 54 patients exhibiting positive skin tests with toxoplasmin antigen and in 20 of the 46 patients in whom negative toxoplasmin skin tests were obtained. Thus, 63 Sabin-Feldman Dye studies were reported. The positive skin test group demonstrated positive titers in 37 out of the 43 patients tested, while those cases with negative skin tests showed positive Sabin-Feldman Dye titers in 6 out of 20 patients (see Table VII).

Foci of Infection.—When focus of infection studies were initiated, consultation was routinely obtained with the Departments of Otology, Urology and Oral Surgery. In selected cases, Internal Medicine and Gynecology consultation was also obtained.

The only significant positive findings in the 29 patients who were so referred were reported by the Department of Oral Surgery. In four cases they felt that abscessed or carious teeth might account for a possible source of focus of infection.

Discussion

No attempt will be made to correlate final visual acuity with the various therapeutic regimens employed because of insufficient follow-up, but rather the discussion will center on the influence of the diagnostic evaluation on the selection of therapy.

Since none of the eyes in this series were available for tissue diagnosis or culture, all diagnoses must be considered presumptive rather than definitive. A presumptive diagnosis was arrived at in only 52 out of the 100 cases analyzed. These are listed in Table VIII. The three etiologies implicated in this group included toxoplasmosis, histoplasmosis and sarcoidosis.

The diagnosis of toxoplasmosis was made on the basis of a positive Sabin-Feldman titer of 1:16 or greater with a compatible fundus picture, usually consisting of an exudative choroiditis, most often seen in younger individuals and commonly associated with multiple areas of healed chorioretinitic leisons.

Histoplasmosis was considered the presumptive diagnosis in 13 patients where the following criteria were present[7]: (1) Positive histoplasmin skin test; (2) complement fixation titers of 1:8, or greater;

TABLE VII. SABIN-FELDMAN DYE TITERS

	Positive Toxoplasmin Skin Tests	Negative Toxoplasmin Skin Tests
1:16	3	1
1:32	3	2
1:64	5	0
1:128	7	0
1:256	5	1
1:512	5	1
1:1014	2	0
1:2048	8	1
1:4096	3	0
1:8192	2	0
Total	43	6

(3) "typical" ophthalmoscopic picture of chorioretinal macular disease. There were several cases in the histoplasmosis group that, in addition to the above criteria, demonstrated elevated Sabin-Feldman Dye titers. These cases were considered to be presumptively due to histoplasmosis since the clinical picture closely followed that described for histoplasmosis. The single diagnosis of sarcoidosis was made in a patient who exhibited nothing in addition to pulmonary lesions compatible with the previously substantiated tissue diagnosis of systemic sarcoidosis.

Conspicuous by its absence as an etiologic agent in this list is tuberculosis. Although 25 per cent of the patients exhibited tuberculin hypersensitivity, it was felt that the presence of a positive skin test alone or in combination with pulmonary calcification was insufficient evidence upon which to base a presumptive diagnosis. Its importance lies in the election of a therapeutic program.

There are four treatment programs employed at the University of Michigan Medical Center. These include the use of intravenous Amphotericin B (Fungizone, Squibb) with sulfadiazine in presumptive histoplasmosis, and the ultilization of Daraprim and sulfadiazine in cases of presumptive toxoplasmosis chorioretinitis.

In the remaining cases in which no presumptive diagnosis was arrived at (and in the single case of sarcoidosis), treatment with systemic steroids was instituted. In this group, treatment with isonicontinic hydrazide (INAH) and paraamino-salicylic acid (PAS) was added to the regimen if tuberculin hypersensitivity was present. This was done for two

TABLE VIII. PRESUMPTIVE ETIOLOGIC DIAGNOSIS
100 Cases

Etiologic Disease	Per Cent
Toxoplasmosis	38
Histoplasmosis	13
Sarcoidosis	1
Unknown	48

reasons. The first and most important reason was to "cover" the patient with antituberculous drugs in order to prevent a flare of an old tuberculous process. Second, this also treated the remote possibility that tuberculosis was the etiologic agent involved in the chorioretinitis.

Although a possible focus of infection was thought to be present in four cases, the presumptive diagnosis of chorioretinitis secondary to this focus was not seriously considered. It is generally felt by the Department of Ophthalmology at the University of Michigan Medical Center that in the light of our present knowledge the concept of a focus of infection causing chorioretinitis must be considered unlikely and that consultation with allied services should be reserved for selected difficult cases.

It is obvious that in spite of an extensive etiologic survey, with many laboratory tools, just as often as not the ophthalmologist is left in the undesirable position of having to treat a devastating disease with non-specific therapy. In this series only 3 tests measurably contributed to the institution of specific therapy. These included the skin tests and complement fixation studies to the chronic granulomatous diseases and the Sabin-Feldman Dye titer.

The employment of both the toxoplasmin skin test and Sabin-Feldman Dye study in the diagnostic survey deserves further mention. Although the toxoplasmin skin test is a good indicator of possible toxoplasmic chorioretinitis, it is far from infallible and it is not recommended that the skin antigen be used to the exclusion of the Dye study. As noted earlier in this report, negative Dye studies were obtained in the presence of positive skin tests (6 of 43) and postive Dye titers were found where negative skin hypersensitivity to the toxoplasmin antigen was absent (6 of 23 cases). It is therefore advisable that

both tests be routinely used in the chorioretinitis etiologic survey.

The value of the skin test lies in the availability of the report after forty-eight hours, whereas the Sabin-Feldman Dye titer report is usually delayed at least two to three weeks.

The focus of infection survey, chest film, serological test for syphilis, urine sugar and albumin, and brucella agglutination did *not* significantly contribute to the therapy in a single patient so studied.

This is of practical value to the ophthalmologist treating chorioretinitis in private practice. At the University of Michigan Medical Center the chest film, urinary studies and serological test for syphilis are routine and there is no charge beyond the usual registration fee for these procedures. Referring patients to the various clinical services carries with it a nominal charge. This is not the case in the private practice of ophthalmology where the laboratory and consultation fees would be proportionately larger.

Because of the often devastating nature of the disease, it would still be ideal if all patients with chorioretinitis were exhaustively studied in an attempt to implicate even the most remote etiologic possibility. Unfortunately, this is not possible and not infrequently a practical compromise must be sought.

When economic and social considerations dictate a shortened uveitis etiologic evaluation, it is therefore recommended that the following survey be employed:

1. Skin tests to toxoplasmosis (and control), histoplasmosis and tuberculosis.
2. Complement fixation studies to histoplasmosis, coccidiodomycosis and blastomycosis.
3. Sabin-Feldman Dye titer.

The charges for these procedures are quite reasonable. The skin testing material to histoplasmosis and tuberculosis is supplied free of charge by the State Laboratories in Lansing, Michigan. Toxoplasmin skin-testing material can be obtained from the El Liilly Company.

The complement fixation studies can be obtained by sending 10 cc. of clotted blood to the State Laboratories from where it is then transported to the United States Public Health faculty in Chamblee, Georgia. This is done at no charge to the patient.

We have been sending blood samples for the Sabin-Feldman Dye titer (toxoplasmosis) to the South Bend Medical Foundation in South Bend, Indiana. The fee for this test is $15.

Thus, with this abbreviated workup it is possible to perform the most important facets of an extensive outpatient evaluation at a cost of less than $30. This is an important consideration in most economic situations.

Summary

1. The results of the etiologic survey utilized in the evaluation of patients with chorioretinitis at the University of Michigan Medical Center between February, 1959, and July, 1960, are analyzed.

2. A presumptive etiologic diagnosis was made in slightly over one-half of the cases.

3. Cases diagnosed as toxoplasmosis chorioretinitis received Daraprim and sulfadiazine therapy often combined with systemic steroids. Those patients with a presumptive diagnosis of histoplasmosis had Amphotericin B administered intravenously and received sulfadiazine orally. In those patients where no etiologic agent was uncovered in the survey, systemic steroid therapy was used.

4. An abbreviated etiologic evaluation is outlined for those situations where social and economic conditions dictate the need for such a program.

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Ocular Photography

William J. Slack, M.D.
Detroit, Michigan

THE PURPOSE of this paper is to illustrate how anyone can take excellent photographs of the eye utilizing moderate cost equipment available in almost every photographic supply store.

Equipment

Equipment requirements include: (1) Camera—Contaflex III; (2) Illumination—Heiland Strobonar, Model 64B and quick release brackets; (3) Lenses—Proxar 0.2 meters, 0.3 meters; (4) Special Supplementary Lens; and (5) Microscope Adapter Ring (Zeiss Co. for Contaflex)—all at total cost of about $200.00.

The Camera.—Any single reflex could be used, but we recommend the Contaflex III single lens reflex, 35-mm. camera because of its versatility, compactness, precision workmanship and excellent optical qualities. It is a single lens reflex type camera embodying a singlar lens system for viewing and taking the picture. This feature allows the photographer to view exactly what he is going to record without problem of parallax, which could be of great significance when one takes such extreme close-up pictures. A single lens reflex camera eliminates this completely.

The viewing system is especially bright, large, and being eyelevel is handy to use.

The shutter is a compur type having a variety of speeds, as well as being internally snychronized for all artificial illumination: that being "M" for flashbulbs, and "X" for strobe light.

The lens is an f2.8, 50 mm. Zeiss product with f-stops from 2.8 to 22.

The focusing ring is mounted anteriorly on the camera easily within finger reach.

The 1960 Contaflex models have made it possible to purchase the older Models I, II, and III at bargain prices—ranging from $65 to $110 for the I and III, respectively, and allowing substantial reduction in total equipment cost.

Illumination.—In color photography, one desires so-called "flat-lighting." This is to say, lighting without shadow. In black and white photography, degrees of shadow are desirable when utilized properly, but not with color photography. Therefore, it is best to position the strobe unit so it will be centered in front of the face; thereby equally lighting both sides (Fig. 2A). Not only that, but in this position it also illuminates the background on both sides of the head.



Fig. 1. Shown is the complete equipment necessary to take ocular photographs—camera, lenses, microscope adapter, and strobe light and brackets.

We use a Heiland Model 64B strobe light. Of particular importance is the fact that the strobe face is relatively small in size, producing only a small reflex on the cornea on extreme close-up photos. It should be noted here that when working close to the face it is not practical to use flash bulbs because of the danger of bulb explosion.

From the Detroit Receiving Hospital. Dr. Slack is a Resident in Ophthalmology, Kresge Eye Institute, Detroit, Michigan.

The strobe light does not have this dangerous feature and lends itself easily to this type work. It is a repetitive flash of about 1/2000 second duration, color balanced to daylight film, and with a maximum power output of 45 watt seconds. The strobe flash-tube will give about 10 to 15,000 successive flashes with an average time interval of 5 to 25 seconds between flashes for the recycling procedure. The Heiland Model 64B strobe light is activated from house current or from 3 D-size ordinary flashlight batteries. This gives a recycle time of 5 seconds on house current, and 25 seconds on batteries. Both recycling times are short and of little inconvenience. With recycling completed a "ready light" glows visibly indicating the unit is ready to flash again.

When being operated on batteries, the unit is completely contained in one piece with no cords dangling down to a separate power pack. This facilitates its portability, with one carrying it easily into the Emergency Room or Operating Room. The electrical unit is self-contained when in this portable form and so offers only little opportunity of external electrical discharge and subsequent anesthetic explosion in an operating room.

It is simple to pick up the camera unit, plug in the flash, expose and keep right on exposing just as easily. For a picture in the next room, simply flip the switch to the battery cycle, and it will be "ready" by the time you get there. It is easily carried from room to room, building to building, or city to city.



Fig. 2a. This is the basic method of holding the camera and light for all situations except the ultra-close pictures. Note how the left hand holds the back of the strobe light against the forehead and directed at the subject.



Fig. 2b. The camera body is held the same way with the right hand, but the strob light is in a slightly changed position. It now is held to the left side and close to th left edge of the camera bracket, while being directed more inward toward the eye.

This particular strobe light does have some disadvantages, though. It is too heavy to carry about all day, weighing 2 pounds 15 ounces with batteries, but for our use it is perfectly satisfactory. Also, the unit's power is adequate for close pictures but not adequate for anything farther away than 10 feet when using Kodachrome film. It cannot be used continuously on batteries, either. It must be "recharged" occasionally with house current, but this feature is negated by using it in the office as suggested in this paper.

The strobe light manufacturers make a special bracket to attach the strobe light to the camera. It is designed to allow quick and easy release of the light from the camera. They call it appropriately a "quick release" clamp. Because the synchronization cord is coiled and extends to about 4 feet in length the light may be placed in multiple special positions while detached from its camera bracket.

Film.—Kodachrome Daylight type is used for almost all our work as it gives good, balanced colors

and with our strobe light is fast enough for our working conditions. At present we are experimenting with Ektachrome film with the slit lamp technique to achieve a higher f-stop and more depth of field.

In our transparency copying technique we use Kodachrome (Professional) Type A film.

Techniques

Holding the Camera.—The camera is light enough to be held comfortably with one hand—the right one. You grasp it in the right hand with the index finger poised to push down the shutter release on the top of the body at the right end of the camera (Fig. 3). The strobe light is manipulated with the left hand.

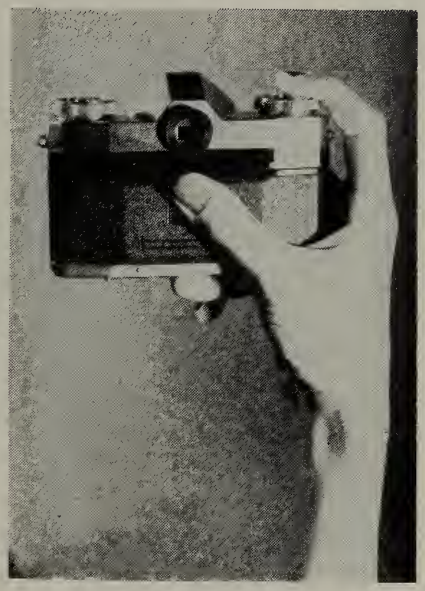


Fig. 3. The ease with which one can easily hold the camera is shown here. Note the right index finger poised to trip the shutter release located atop the right side of the camera within the knurled ring.

Following each exposure, merely slip the U-shaped end of the strobe light bracket into the curved index finger of the left hand. This fixates the camera, allowing release of the camera from the right hand. Then with the right hand you turn the knurled knob at the right end of the camera, simultaneously advancing the film, counting the frame, and cocking the shutter (Fig. 4). It is easy to again grasp the camera with the right hand, and continue on to take another picture. This procedure of advancing from one picture on to the next takes about 5 seconds.

Lenses Used.—We utilize the Contaflex standard close-up (Proxar) supplementary lens to focus from 2.5 feet to 6.25 inches. These are easily attached to the front of the camera with slip-on mounts. For bilateral ocular views to include the forehead, nose, lips, and ears, use the .3M (meter) lens. To concentrate detail on just both eyes, the .2M lens is used (Figs. 5-7).

Because the camera is so close to the face in taking the close-up pictures (about 4 inches to 6 inches), it is of great concern to have as streamlined a close-up lens as possible on the camera. This will give plenty of room to get the strobe lighting to the eye. To eliminate this problem we had a special lens ground for our ultra-close pictures, a lens which is as thin as possible yet powerful enough. One could add 2 or 3 .2M lens on top of each other and get the desired effect, but the combination of lenses is large and projects close to the face, blocking out some of the strobe illumination.

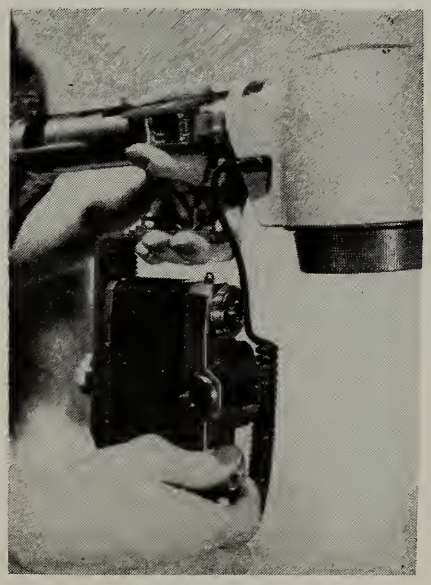


Fig. 4. The camera is shown supported in the curved fingers of the left hand while the right hand advances the film for the next picture.

A plus 21D lens will focus the camera so that the interpalpebral area of one eye fills almost the whole frame—a slightly greater than 1:1 ratio (Fig. 8). This lens was specially ground at a local optical company* and fit into a standard camera filter mount. The lens can be coated readily if you so desire to reduce reflections.

Recently Zeiss has offered a close-up lens element for the Contaflex III which gives a 1:1 ratio. The lens

*Bayne Optical Company

is actually three lens in a single unit which replaces the front lens elements of the 50 mm. regular Contaflex III lens. It is worthy to note that this new lens



Fig. 5. This shows the field covered without any supplementary lens and with the camera focused at 2½′.



Fig. 6. Using the .3M lens the field photographed is roughly limited to the face alone.



Fig. 7. Using the .2M lens only the area immediately about the two eyes is included. Note the small upper lid tumor located medially O.S.

will *not* adapt to any Contaflex I or II, but only models III, IV and the newer models, all of which have interchangeable front lens elements.

Camera Settings (f-stops and time).—The flash duration for the strobe is 1/2000 second. With the shutter set for 1/250 or 1/500, there is little light except that of the strobe recorded on your film so the shutter speed is said to be "1/2000th second." This means that you "freeze" all action of the eye. It also allows you to slowly move backward and forward with ease while focusing and to trip the shutter while actually moving about. Because of this high shutter speed you do not get blurred pictures.

The f-stop designation is the size of the opening in the leafs of the shutter diaphram. The higher the stop, the smaller the opening, and also the greater the depth of focus achieved. When considering the proper f-stop, the degree of pigmentation and skin color in general is of importance. In the very young, elderly, and chronically ill the skin is very light, requiring a higher f-stop than in the normal, ruddy complexioned person.

With the camera utilized without extra lens and focused at 2.5 feet, one finds f5.6 is the correct f-stop for all but the very lightest complexioned subjects. (For the light complexioned person, we go to f8.). When utilizing any of the close-up lens, including the special lens, f11 is the setting to use with the normal person. If the patient is either very young or elderly, pale, and blue eyed, f16 should be used.

Summary

Without Supplementary Lenses—focus at 2.5 feet
f5.6—normally pigmented person
f8.0—light complexion person
With all Supplementary Lenses
f11—normally pigmented person
f16—light complexion person

In general, one can say f11 is utilized when photographing normal complexioned people using any of the supplementary lens. Experience will quickly tell you when to use a larger or smaller f-stop.

Focusing.—As previously stated, the Contaflex is a single lens reflex type camera, with the operator viewing and focusing through the one lens complex. A mirror is interposed between the lens and the film plane, reflecting the rays of incident light to the viewing system. An instant before exposure the mirror slips away allowing the light rays to go to the film plane and expose the film. This method of viewing and focusing allows the operator to see exactly what the camera will record at exposure.

When focusing through the Contaflex viewing system, one sees a central clear area on the ground glass having a "doughnut configuration." The outer ring of the "doughnut" is a fine ground-glass focusing area, while the central "doughnut hole" is a split image type rangefinder. To focus with the former you merely get the desired image sharp and clear on the ground

glass by moving the camera focusing ring back and forth until you reach the desired focus. The split-image rangefinder in the "doughnut hole" is slightly different. Here you select some vertical place to focus on. When the camera is out of focus the vertical lines are not in alignment and appear separated a few millimeters on the 180 degrees Meridian. When the camera is in focus the two vertical lines will be in vertical apposition forming a straight line in the 90 degree Meridian. The focusing is fully discussed and well illustrated in the camera manual.

A very great advantage of this technique and equipment is that we are able to place the focus of the camera on the pathology instead of utilizing the more common but less efficient method of prefocused lens

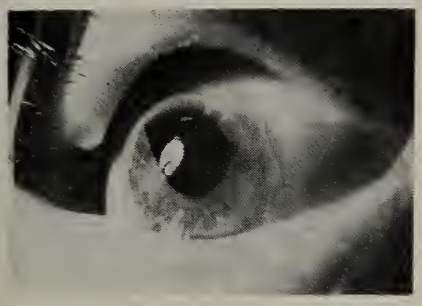


Fig. 8. Picture taken with special supplementary lens showing an anterior chamber cyst located at the 2:00 position.

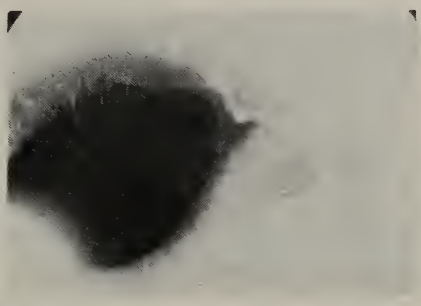


Fig. 9. Same as Figure 8 but the picture was taken through the Poser slit lamp and showing the epithelial cyst in the described location.

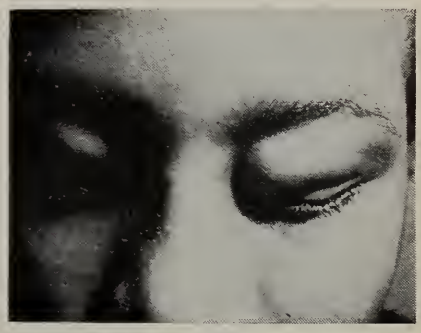


Fig. 10. This is the same lady as seen in Figure 7 but by the placing of the light above and slightly behind her one is able to bring out the presence of the upper medial lid tumor.

coupled with frames. Frequently the patient's facial and ocular configuration will not allow the frame to get the area you desire into crisp focus, and a blurry picture results. This method allows you to focus exactly on the ocular pathology desired and to obtain crisp, detailed photographs.

In our work with such powerful close-up lens utilized, the focusing mechanism on the camera has little effect, so we utilize a slight variation of the above technique. By setting the range-finder focusing ring at infinity, or 2.5 feet, one need only to move the whole camera back and forth until the image you desire is sharply focused. One may use either of the methods mentioned for determining focus, but I find the ground glass focusing the easiest for the extreme close-up pictures. Either may be used with equally good results.

Lighting.—The special supplementary lens requires that the strobe light be held in a particular position, as shown in Fig. 2B. The light is held close to and slightly above the light bracket on the camera with its housing directed down and in. Some mechanical difficulty will be noted when photographing the left eye, but it is easily remedied by shifting slightly lateralward. This allows the light to be directed correctly and adequately toward the eye. At this close range the strobe light reflex is larger, but if placed in the proper position as shown, the reflex falls off the eye and is not recorded at all in many cases.

Although the strobe light has a 70 degree field coverage, it is best to remove it from the camera with each exposure. On all but the very close pictures the light is held with the back of the lamp housing against the forehead immediately above the camera (Fig 2A). In this position the subject has a balanced illumination, producing a desirable three-dimensional effect. When taking the facial lesion from an oblique angle one may hold the light either above or to either side of the camera, depending on what effect you wish to obtain. If the lesion is laterally placed on the face with the camera positioned straight at the lesion, the light is held above the camera in the previously described manner. If the lesion is on the front of the face but the camera is oblique to the face, the light is held in front of the face. This maneuver illuminates the whole anterior face equally, plus the background.

Special effects may be produced by holding the strobe light in different positions about the face. With exophthalmous, or depression in the orbit and skull, you hold the light above and behind the leading edge of the afflicted area. This way the light casts a shadow downward outlining the pathologic area. Note how this technique amplifies the lid tumor, originally

photographed the usual way as in Figure 7, as seen in Figure 10.

As long as you keep the strobe light as far away from the desired lesion as the camera is, you may move it about freely and get perfect exposures.

Patient Instructions.—The patient is told that an ordinary picture is going to be taken, and that a bright flash will be seen. With the strobe light so near patients frequently feel a flash of warmth with the light flash, so one may anticipate this reaction and explain it prior to exposure.

If you need the lids separated, the patient can do it for you, or your office nurse can assist you. Patients are most willing to help usually.

Fixation is easily achieved by having the patient look at your camera lens or at a suggested target.

Usually the patient is cooperative and the procedure takes little time. About one minute for three or four pictures.

One finds most children like to have pictures taken and cooperate well with few exceptions. Infants may have to be photographed after restraint is carried out by wrapping them in a sheet. Remember, movement does not affect your photo end-results.

Example Procedure

As an example, let us say you have a case you would like to photograph. A picture of a corneal lesion, for instance. Here is what you would do using this system.

Activate the strobe light (house current or batteries) and cock the shutter. Since you wish to photograph both eyes at first, place the .2M Proxar lens on the camera. The strobe "ready light" will be on now, signifying the unit is fully charged. Set the f-stop at 11, place the strobe light as directed with the lamp housing's back surface against your forehead, and grasp the camera as directed. Now, while viewing through the range finder, move in slowly toward the patient until the eyes are in perfect focus. Quickly trip the shutter at that instant and the picture is taken. Total time: about half a minute.

If you have the camera set up in the office with the .2M Proxar lens on, f-stop at 11, time at 1/250, and focus set at infinity you only need to activate the strobe light, focus, and snap the picture. It is very easily done.

Now to photograph just the involved eye, you remove the .2M Proxar lens and slip on the special supplementary lens. Here you have to make a special placement of the strobe light, as per diagram 2B, but you focus and make the exposure the same way. With the special supplementary lens one notes that a slight motion will bring the image to focus but also quickly throw it out of focus. Here is where the speed of the unit facilitates good pictures since you expose the picture while you are slowly moving in or out—and no blurred picture results.

Special Techniques

X-Ray Copying.—To copy x-rays, one need merely to put the x-ray on a fluorescent viewing box which is easily masked to the desired x-ray size using an ordinary desk blotter with the appropriate-sized hole cut from its center. Exposure is calculated for the area desired with a Weston meter and the exposure made. Usually it figures to about f4.0 to f5.6 at 1/30 second duration. The camera must be tripod supported here because of the relatively long exposure time.

Using the appropriate Proxar lens you merely select the field you desire to record and focus down on it. When utilizing this technique I find a .5M Proxar lens helpful also.

The final pictures are a light green color instead of the true bluish-white that x-rays really are, but we do not find it objectionable. With careful selection of the exposure, you can get good copies of x-rays without loss of fine tone definition.

Ideally you should use a pre-exposure technique. Details of the process are available from Eastman Kodak Co.

Slit Lamp Pictures.—In those cases where high magnification of a specific area is desirable, as in Fig. 9, the Contaflex may easily be adapted to fit the Bausch and Lomb Poser Slit Lamp. As a standard accessory, Zeiss produces a microscope adapter of two pieces. One piece is a large barrel designed to fit on the housing of the slit lamp ocular and the second is a ring adapting the camera to the barrel. Remove the slit lamp ocular, slip on the large microscope adapter piece and replace the ocular. Then attach the adapting ring to the camera and put the camera on the large barrel housing as per instructions. The whole assembly is moved forward so that the ocular tip just touches the camera lens mount assembly. Tightening the fixation screw on the assembly locks the camera to the eyepiece. Now by viewing through the camera one sees through the optics of the slit lamp.

Illumination for focusing is provided by the regu-

lar slit lamp illumination. By setting the focus at infinity one may get any part of the viewing field in focus by regulating the slit lamp focusing mechanism. To illuminate the field or film exposure the slit lamp light is moved to one side and the strobe light is held at the lateral canthus about 3 to 4 inches away from the eye. At this distance an f-stop of 4.0 or 2.8 will give correct exposure in a dark pigmented individual. Blue eyes, and light eyed individuals require f4.0 to f5.6.

Note that you do NOT photograph the beam slit using the technique.

35 mm. Transparency Copying.—By using the Special Supplementary lens one may copy other 35 mm. transparencies. The technique involves interposing the transparency you desire to copy between a light source and the camera. To obtain accurate color reproduction the film in the camera and the light source must be color temperature matched. This problem is easily solved by using Kodachrome type A film and a 375 watt photoflood light, both matched to 3400 degree Kelvin color temperature.

The light source is placed behind a 1-foot square wooden shield which has an opening in the bottom slightly larger than the actual film area of a 35 mm. slide. This shield allows light to come through the one hole only, and makes focusing much easier. To diffuse the light a small piece of plain white paper is placed over the light-side of the small opening. A fixation device holds the transparency at the desired position.

The Contaflex with the special supplementary lens on is placed in front of the transparency at the distance required to get perfect focus—approximately 75 mm. from the central anterior surface of the camera body (with the lens set at infinity). In this technique it is easiest to use the groundglass focusing system, but on occasion the rangefinder system is of advantage.

The Eastman Kodak Co. production-tests all Type A color film using 1/25 second exposure so it is best for one to utilize this shutter speed while copying. The variable here is the proximity of the light source to the transparency, i.e., the closer the source to the transparency the more light comes through. Using a Weston Master lightmeter's more sensitive cell, measure the light coming through the transparency—and move the light back and forth until you get enough light transmitted to require 1/30 second exposure. With a dark picture the light will come close to the transparency, and with a lighter picture it will be quite distant from it. So, get the transparency in focus, adjust the photoflood light to the proper distance, set the f-stop to the appropriate f-stop and expose. You may follow the procedure to make one or one hundred copies of the same picture.

This technique has the advantages of critical light control which allows you to improve over the original copy. The ones that are too dark you overexpose slightly to make the copy lighter, and vice versa for the light transparency. But the equipment is somewhat cumbersome, and hot due to the use of a photoflood light source.

At present, although we still use the above technique largely, we are developing a simplified technique utilizing the strobe light for a light source. It is our plan to have the light source fixed and have need only to vary the f-stop to obtain correct exposure.

Another advantage of a strobe light source is that one can use Daylight film which eliminates a need for switching films. One disadvantage with Kodachrome Type A is that it comes only in 36-exposure rolls. Daylight Type film comes either in the standard 20 or 36-exposure rolls.

Biopsy Photos.—Through the use of the three Proxar lenses and a blue, or green towel for background, you may easily and quickly photograph all your tissue specimens. If they are very small place on a clean microscope slide suspended by two wooden 1-inch square blocks off a blue background. Hold the strobe light about 6 inches away from your forehead but directed down toward the specimen. Set the camera at f11 or f16 and expose.

Summary

1. Presented is an ocular photographic technique of simplicity and accuracy.

2. This paper shows how one camera and supplementary equipment can be utilized to do multiple jobs in the ophthalmologist's practice.

3. It proves that non-specialized equipment can be utilized in producing good ocular photographs.

4. It shows that equipment which is not especially designed nor in need of any permanent modification, can be used in the system for producing ocular photographs.

The Human Electroretinogram

A. D. Ruedeman, Jr., M.D.
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THE HUMAN ELECTRORETINOGRAM is at present being studied in laboratories all over the world. The purpose of this paper is to relate to you the recent findings of the Electroretinography Laboratory in the Kresge Eye Institute. The laboratory is presently beginning its fifth year of activity and to date more than 500 patients have been tested, many of them more than once and some seven or eight times.

At the same time we wish to reiterate and re-emphasize the clinical value of the electroretinogram (ERG) and to point out its potential use in the everyday diagnostic armamentarium of the ophthalmologist. Objective tests of function are rare, more important. Modern medicine has placed more and more stress on the prevention of disease which has made the objective evaluation of function necessary. All of us are aware of the many electronic tools which have come along to take part in the determination of physiologic processes. Among these is the subject for discussion, namely the appartus and procedure used for determining the electrical potential of the retina as stimulated by light.

There are sceptics who point out that the electrical potential evolving from the retinal stimulation by light, is actually the result of diffuse light entering the eye, in essence a mass response. It is then pointed out that the response is too complex to determine a particular retinal defect, especially central, or to localize an area of diminished function. Since the presently utilized light sources cannot be focused accurately, this mass response is felt to be inadequate to the needs of the clinician who must have a specific test for a specific part.

Here the discusser would take issue with the above. First, even though the response is a result of the mass stimulus, previous observers have been able to break the ERG into rather clear-cut component parts. For instance, the a-wave is believed to be a result of change in potential in the area around the outer limbs of the visual cell. The b-wave is a result of change in potential in the area of the inner limb of the visual cell and the bipolar cell. The c-wave, a potential change occurring in the area of the pigment epithelium. Early investigators have noted that certain stimuli cause a response from the retina which may be due to photopic or scotopic processes, e.g., the response to colored light and the response to a flickering light apparently indicate photopic responsiveness.

Some of these determinations have evolved from repeated and careful investigation of animals utilizing the response from a single cell or the response obtained after cells have been poisoned by specific metabolic agents. Repeated examination by various observers on human subjects tend to bear out and strengthen the experimental findings. It is not necessary to repeat once more our feeling that the electroretinogram can be used as a clinical tool, utilizing experimental conditions. Suffice it to say that we follow a standard procedure for each patient so that normal and abnormal cases can be compared readily and the results obtained subjected to standard statistical evaluation.

In our laboratory, at the present time various procedures for the evaluation of the electroretinogram are under way. First, let me say that with the present testing conditions and equipment, it would appear that we are able to get reproducible results from the same patient at different times so long as retinal function is constant. Comparable electroretinographic results may be obtained regardless of whether portable or fixed equipment is utilized.



The Author

A. D. RUEDEMAN, JR., M.D.

The data from our series of cases involving the posterior central retina are presently undergoing statistical evaluation. From the cases evaluated to date, as compared to known normal individuals there is no doubt that the electroretinogram in those patients with posterior central involvement of the retina is consistently abnormal. To date we have evaluated cases of hereditary juvenile and adult central pigmentary degeneration, Kuhnt-Junius disease with or without pseudo-xanthoma elasticum, senile macular disease, uveitis involving the posterior central retina, and central and peripheral visual cell degeneration.

Before final statistical evaluation, the results to date would indicate that with unilateral or bilateral posterior central disease there is a reduction in the electroretinogram from normal levels, there is a general slowing and flattening of the components of the a-wave, there is a reduction in the response to red light, and a reduction in the response to the flickering light. The clinical impression of a centrally located lesion is not well borne out by the ERG. For example, our cases of angioid streaks without central involvement have abnormal ERGs. As the disease progresses the ERG becomes worse.

We are also going to evaluate a series of normal patients at repeated intervals under various external conditions and times utilizing both fixed and portable equipment. We are going to subject the response to a flickering light to Fourier analysis which should allow us a more sophisticated evaluation of the character and parts of the flicker response.

We are at present constructing an ERG apparatus utilizing principles recently set forth by Armington.[1] In essence, this consists of a totally computorized ERG system which allows the evaluation of a very low intensity stimulus upon the retina. The technique is similar to that utilized in recovering electronic stimuli from the various satellites coursing through space.

On the basis of studies performed in the laboratory on patients ranging from five to eighty-five years of age and on whom adequate examinations and re-examination could be performed, we feel that the electroretinogram is of clinical value in the following circumstances:

1. Differential Diagnosis.
 A. An optic nerve from a non-optic nerve disease
 B. Visual cell damage: (1) Peripheral from central retinal degeneration. (2) Peripheral and central retinal degeneration

2. Diagnosis—congenital stationary night blindness, retinitis pigmentosa, congenital amblyopia on the basis of total visual cell degeneration, unilateral versus bilateral disease.

3. Objective evaluation of the progress of a disease, e.g., retinitis pigmentosa.

4. Recognition of an otherwise unsuspected disease process of the retina; for instance, unexplained amblyopia in a young child, or an adult for that matter.

5. The evaluation of a hereditary visual cell degeneration. In the future we must consider the possible utilization of tests which reveal potential weakness in cell function. Since many of the hereditary visual cell degenerations begin in young prereasoning children, the objective test for function becomes a necessary implement to diagnosis.

6. Retinal detachment. Evaluation of retinal function in retinal detachment has been interesting from several points of view. In the first place, retinal function in the unaffected eye is often markedly reduced. The possibility of determining a critical retinal function level prior to physical retinal change must be considered. Also, the poor retinal function noted in many severe cases of retinal detachment and the number of cases which show real improvement in the ERG following maximum surgical intervention makes one more anxious than ever to determine the earliest detachment situation in order to prevent the serious progress of the disease. The studies on retinal detachment are still in progress and a final conclusion can not be discussed at this time.

7. Comparison of function in both eyes in a monocular or binocular disease.

In a period of over four years of active investigation of various retinal diseases by electroretinographic technique, this observer is more enthusiastic than ever over the potential diagnostic function of this tool in ophthalmologic disease.

Reference

1. Kropfl, W. J., Robinson, R. E., Armington, J. C. and Tepas, D. I.: An analogue computer for separating evoked physiological potentials from background noise. Conference Proceedings of IRE, 4th National Convention on Military Electronics, New York, 1960.

Indications for the Removal of Cataract

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IT MAY SEEM OBVIOUS that cataracts should be removed when their presence interferes with vision but, because of possible complications, both organic and psychologic, associated with cataract extractions, optimal conditions should be determined for such surgery. Let us consider some of these conditions:

Cataract in Adults

Unilateral Cataract.—When one lens is clear and the vision good in that eye, the general rule holds (the exception will be discussed below) that the cataractous eye should not be operated, no matter how reduced the visual acuity. The reason for this is that the patient will still continue to use the noncataractous eye and begin to doubt the purpose of the operation since he still cannot use the operated eye. Verbal explanation as to the inability to use both eyes together after operation to remove one cataract is not usually understood before experience makes this reality manifest.

However, there are some special situations in which unilateral cataract extraction is reasonable and indicated. These are (a) traumatic cataract in which either an experimental anterior chamber lens or a contact lens is planned, (b) swollen or hypermature cataract, (c) where, for cosmetic reasons, the patient desires the cataract removal, and (d) in industrial situations where the presence of the cataract is a hindrance to employment. Involvement of the visual field is sometimes used as a reason for lens extraction in monocular cases. Often, the patient does not realize or appreciate the advantage obtained.



The Author

H. SAUL SUGAR, M.D.

Traumatic Cataract: When the onset of traumatic cataract was before the age of seven or eight, one must suspect the possibility of amblyopia when dealing with the patient when he is examined at a later age. If the injury has occurred after seven or eight, a contact lens or an anterior chamber lens (still experimental) may be effective in giving binocular vision.

Unless surgery is necessary within a short time after injury, the eye should be free of any inflammatory signs for a year before elective surgery is considered.

Unilateral Swollen or Hypermature Cataract is an indication for surgery to prevent both the formation of spontaneous capsular dehiscenses and phakolytic or secondary angle-closure glaucoma. It may be helpful in these cases to give a lateral field of vision for security reasons.

Industrial Situations: When unilateral cataract is removed for industrial reasons, the correction is given with a regular cataract lens for the operated eye and the usual correction for the unoperated eye. This produces diplopia, but the glasses are used only to pass the visual tests since most industrial examiners are interested, not in binocularity, but in the corrected vision with each eye.

Bilateral Cataract, Incipient in One Eye and Advanced in the Second.—

Incipient Cataract in the second eye is an indication for surgical removal of the cataract in the first eye if the vision in the second eye is somewhat reduced, perhaps to 20/30 or less. This brings up the question of the visual acuity as a measure of the indication for cataract extraction. It is obvious that when the visual acuity measurement in each eye is 20/50 or less, usually 20/70 or less, that cataract extraction in one

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eye is indicated, yet there are cases with 20/25 acuity in each eye and inability to carry on one's visual activities for near distances. Cataract extraction should be done in such cases to follow out the axiom that cataract extraction is indicated when the lenticular opacity interferes with the carrying out of the usual visual functions for the individual. One should keep in mind that a patient with bilateral central posterior subcapsular cataracts may be unable to see at all clearly in bright light but when the patient is measured behind the refractor, the pupils dilate in the subdued light and the visual acuity is much better than under outdoor conditions.

A very important factor in the decision as to surgery in bilateral cataract cases is the determination of the status of the retina and optic nerve. When one eye has only an incipient opacity the status of the fundus of the more densely cataractous eye can be inferred from the one more easily studied. In cases where both lenses are moderately opaque, the use of the Schepens binocular indirect ophthalmoscope makes possible a view of the fundus which is impossible with the direct ophthalmoscope. In cases of retinal detachment with cataract, the cataract may be removed to permit visibility of the fundus.

Age is not a contraindication to cataract surgery.

Cataract in Severely Damaged Eyes.—This may be an indication for extraction if there are the same indications as discussed above and if the patient is totally blind. The one requirement is the perception of light and some projection. Even poor projection is sometimes followed by good vision after extraction of a very opaque lens. The eye should be quiet. Even band opacity of the cornea may not be a contraindication as is shown by the following case history.

History of Case

H. F., Polish refugee woman, aged thirty-eight, was seen on June 17, 1957. She gave a history of a severe uveitis in both eyes twelve to fourteen years previously. Vision was hand movements right and finger-counting at 6 inches left. Bilateral cateracts and old posterior synechias were present. A band opacity was present on the right cornea. This was treated with 1 per cent hydrochloric acid after removal of the epithelium. This healed quickly, leaving a clear cornea. On June 25, 1957 an intracapsular cataract extraction was done on the right eye. After uneventful healing the right vision was 20/50 with +2.25 +2.00 x 105. The fundus showed myopic degenerative changes. On November 6, 1958 a left intracapsular extraction was done. The corrected vision after healing was 20/400 with +4.00 +1.25 x 110. Myopic changes involved the macula more than on the right. However, the patient was able to carry on independent normal activities as a housewife.

Some of the eyes in this category may have a completely fluid vitreous and no hyaloid membrane so that the lens is held to the iris by posterior synechias. In such eyes severely damaged by old uveitis, it is wise to avoid breaking all the synechias before application of the erisiphake or capsule forceps.

Cataract in the Presence of Mild Chronic Cyclitis as in heterochromic cyclitis may be extracted in the usual manner, with the same indications. Corticosteroids are used before the operation and during the postoperative period.

Nuclear Sclerosis in Highly Myopic Eyes gives a special situation in relation to reading. This has not had sufficient attention in the literature. Such patients with about —20.00 myopia with considerable myopic macular degeneration may still be able to read by removing glasses and holding the reading matter close. If both crystalline lenses are removed, the patient, even with correcting lenses, cannot read. I have in one such case operated on one eye to produce better distance vision with slight correction but the patient had to use the cataractous eye to read with. This inability to read after cataract extraction in such a case indicates that surgery should be postponed until the opacity is so advanced that the patient cannot read without glasses at a close distance.

One-Eyed Patients with Cataract.—When cataract is present in a one-eyed patient it is best to postpone surgery until the patient has "nothing to lose and everything to gain," in other words, until the visual acuity is reduced markedly and the patient requests surgery.

Hypermature Cataract with Glaucoma Due to Angle-Closure or to Phakolytic Factors.—Where the cataract is responsible for the glaucoma, the lens should be removed immediately.

Congenital Cataract

The goal of cataract extraction in children is the same as in adults but the achievement of this goal is more difficult in children. In addition to the indications we must consider the optimum time and type of surgery.

When *monocular* cataract is present from birth, it is best to avoid surgery unless hypermaturity or cosmetic reasons are present. Surgery should then be done as late in childhood as possible. If the eyes are straight and the unilateral immature cataract is removed, the

eye may later cross and the surgeon be held responsible. These eyes are usually amblyopic.

In *bilateral* cataracts, surgery should not be done if the vision is 20/50 or better. Some zonular cataracts which appear to be quite opaque give as much as 20/30 or 20/40 vision and should therefore not be operated before 4 years of age. If there is doubt as to whether the patient has enough vision to get along with, the operation should be defered to 5 or 7 years of age when the vision can be tested better.

The timing of indicated surgery is important. It should be done when anesthesia is easiest. Usually the cooperation of the child cannot be expected, so special techniques are necessary. In complete or nearly complete cataracts I consider three to six months of age as early enough for surgery and that surgery is certainly to be done before school age. Usually one eye is done early and, if all goes well, the other eye is done. Otherwise, one should wait until about two years of age. Remember that in most cases there is amblyopia in one eye and this should be anticipated.

Type of Operation

In infants with complete or nearly complete cataracts, the operation of choice is either needling or, preferably, needling followed in a week by linear extraction with complete iridectomy and, if desired, inferior sphincterotomy. The inferior spincterotomy is done with a blunt scissors after doing the iridectomy. Preliminary massage of the globe is indicated.

In cataracts with liquefied cortex, either spontaneous or following needling, the Fuchs two-way syringe is an ideal method for removal of lens material. It contains a double channelled tube which simultaneously injects fluid through one channel while sucking up substances through the second. These methods are preferable to repeated needlings following which, in some cases, retinal detachment occurs, even many years later. In these cases preliminary iridectomy and capsulectomy are necessary before the detachment surgery. In some even this is not adequate to permit proper visualization.

In using the capsulectomy forceps in linear extraction, one should apply it only once to prevent getting too deeply. In cases where the capsulectomy forceps does not work, one should continue holding the capsule forceps in place and use the cystotome with the other hand. Only gentle stroking on the lower cornea should be used in expressing the lens material. Atropine should be used for at least a month after the eye is quiet.

28 W. Adams

Tells Conference

Director Angus Campbell of U-M Survey Research Center, told the U-M Conference on Aging that:

"Older people are clearly more inclined than younger people to favor government help in getting medical and hospital care at low cost and to approve governmental responsibility for full employment.

"They are slightly more likely to approve a program of public power and public housing. They are no more likely, however, to favor a Fair Employment Practices Commission-type legislation or public aid to education than are young people.

"Attitudes on these welfare issues among the aged are based largely on economic self-interest, not on political ideology.

"While those 65 and over favor federal aid in getting hospital and medical care at low cost, they are the strongest of all age groups in favor of cutting taxes. Similar combinations of attitudes have been found repeatedly in the Center's studies."

Topical Use of Ismelin

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SOME CLINICAL AND EXPERIMENTAL evidence suggests that primary glaucoma may result from disturbance of the balance between the sympathetic and parasympathetic systems, leading to a preponderance of the sympathetic.[1-4] Re-establishment of a normal balance between these systems seems possible by the use of drugs which would strengthen the parasympathetic or weaken the sympathetic stimuli. An attempt was made to do this with different sympatholytic compounds. Of the sympatholytic drugs, ergotamine, other derivatives of *Secale cornutum*, and dibenamine have been most often used.

Ergotamine was used systemically. Some pressure-lowering effect was observed in eyes suffering from one of the congestive forms of glaucoma. In addition, some enhancement of the pressure-reducing action of pilocarpine was noted. These effects were not marked and became even less so after a few days of use. Thereafter the results became contradictory and side-effects were so consistent that ergotamine nearly completely disappeared from use in glaucoma therapy.

Dibenamine, the second important sympatholytic drug, was especially recommended before the introduction of the carbonic anhydrase inhibitors because this compound, which acted as a miotic, reduced the formation of humor aqueous and was able to lower the pressure in the eye. The results were often contradictory and seldom satisfactory and side-effects (especially orthostatic hypotension) so important when administered systemically, that it was tried as a topical application. No effect whatever on eye pressure was observed when instilled, so the drug was abandoned in glaucoma therapy.

Guanethidine (Ismelin®) acts at the terminals of the sympathetic nervous system, without affecting the parasympathetic system. It blocks the sympathetic impulse by intervention at the myoneural junctions.

Keates and his associates[5] used Ismelin intravenously and observed the lowering of intraocular pressure in normal and glaucomatous eyes, especially in chronic simple glaucoma. Untoward side-effects, especially the action in lowering blood pressure when administered systemically, hindered the use of this drug in glaucoma for a longer time.

The drug used in this study is a 10 per cent concentration of the (full) sulfate of guanethidine buffered to pH of 6.1 for topical use, supplied by the Ciba Company. One drop of Ismelin was instilled into the conjunctival sacs of four rabbits at one-minute intervals for a period of five minutes. The intraocular pressure was measured after five minutes and then every fifteen minutes for one hour. No effect on pressure could be observed. No significant effect on pupil size was evident. A slight hyperemia of conjunctiva was noted. The effect of Ismelin on the intraocular pressure and pupil size was studied on fourteen patients with elevated intraocular pressure, eleven with dark irides and three with blue. Instillation of one drop of Ismelin at one-minute intervals for five minutes was made. The tension was measured after five minutes and every fifteen minutes for one hour. No significant effect on pressure was evident. No measurable modification of pupil size was found.

In an attempt to check its sympatholytic action, Ismelin was used in combination with pilocarpine, cocaine, and atropine. It was considered that Ismelin might enhance the pressure-lowering effect of pilocarpine, but no difference was found between the action of combined Ismelin and pilocarpine and pilocarpine alone. One might expect that if Ismelin were used before instilling cocaine, the sympathetic block would decrease the mydriatic effect of cocaine. The sympathomimetic effect of cocaine is achieved by sensitizing the muscle cells to sympathin. No difference in the size of pupils was found when Ismelin was instilled into one eye and later cocaine was instilled into both. In two patients pretreated with Ismelin drops in one eye, the subsequent instillation of atropine into

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Ismelin® is a Registered Trademark of Ciba Pharmaceutical Products, Inc., Summit, New Jersey.

both eyes showed no significant difference in the amount of mydriasis.

In three patients with bilateral chronic simple glaucoma with dark irides, Ismelin was given subconjunctivally in one eye and 4 per cent pilocarpine drops were used in the other eye. In two instances, no pressure-reducing effect of Ismelin was evident, although the intraocular pressure was normalized in the eyes receiving the pilocarpine. In the third patient (one with tensions of 30 mm. Hg right and 46 mm. Hg left), the tension after one hour was 21 mm. Hg in both eyes. In all three patients who received Ismelin subconjunctivally, a slight mydriatic effect of about 2 mm. was evident.

No significant pressure-lowering effect or sympathetic-blocking effect on the pupil could be observed following topical administration of Ismelin.

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Glaucoma

Influence on Cyclogyl and Neosynephrine on Tonographic Studies of Miotic Control in Open-Angle Glaucoma

The work reported compares the tonographic effects of cyclopentolate (Cyclogyl) a parasympatholytic drug, and phenylephrine (Neosynephrine), a sympathomimetic drug, on the intraocular pressure and facility of outflow in eyes under miotic therapy for open-angle glaucoma. Tonographic studies were made on 17 eyes in 9 patients with open-angle glaucoma controlled on various forms of miotic therapy. Tonographic studies were performed during miotic therapy alone, during miotic therapy with Neosynephrine added, and during miotic therapy with Cyclogyl added. Addition of Neosynephrine to the miotic therapy had no consistent effect on the intraocular pressure or tonographic facility of outflow. Addition of Cyclogyl to the miotic therapy usually resulted in an increase in the intraocular pressure over that with miotic therapy alone, and a decrease in the tonographic facility of outflow in every case tested. The fact that mydriasis with Neosynephrine usually does not elevate the intraocular pressure and does not consistently reduce the facility of outflow in open-angle glaucoma (1) allows for its use as an aid in the differentiation of narrow-angle vs. open-angle glaucoma, (2) permits its safe use as a mydriatic for fundus examination in open-angle glaucoma, and (3) points up the fact that the controlling effect of miotics in open-angle glaucoma is not related to pupillary size. On the other hand, use of Cyclogyl (and probably cycloplegics in general) should require more caution in patients with open-angle glaucoma, as the facility of outflow is decreased with Cyclogyl even if the condition is controlled on miotic therapy.—R. A. Schimek and W. J. Lieberman, Amer. J. Ophthal., 51:781 (May, Pt. I) 1961.

Prognosis of Secondary Glaucoma Following Retinal Artery Occlusion with Report of an Interesting Case

Secondary glaucoma following central retinal artery occlusion is a distinct clinicopathologic entity. Approximately four-fifths of eyes affected with this condition were surgically enucleated, according to reports in the literature. The remainder—with the improbable exception of 2—had no light perception. The outcome of treatment has been universally unsuccessful. A case was presented in which there was a central retinal artery occlusion with macular sparing due to a unilateral cilioretinal artery. A second catastrophe was then visited upon the "spared" eye in the form of a secondary glaucoma, the prognosis of which type of glaucoma has been universally and extremely bad. Treatment was surgical and medical. To date, the affected eye still retains useful central vision.—D. I. Weiss and I. H. Leopold, Amer. J. Ophthal, 51:793 (May, Pt. I) 1961.

The Role of Alpha-Chymotrypsin In Ophthalmology

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SINCE Barraquer's address[1] on "Enzymatic Zonulolysis" before the 65th Congress of the French Ophthalmological Society in Paris, May, 1958, there has been a rash of papers published dealing with all phases of cataract extraction with alpha-chymotrypsin.

Discussions on cataract extraction always have been popular, but of late they have been largely rehashes of former discussions because of the paucity of new interesting material. The use of the enzymes has provided the impetus for renewed interest and experimentation.

The discovery of the usefulness of alpha-chymotrypsin in cataract extraction presents an interesting story, illustrating how history repeats itself. In a recent editorial in the *Archives of Ophthalmology*, Dave Cogan[2] wrote:

> Like the argument as to who discovered the usefulness of ether, we (now) have the same problem as to who first used trypsin in cataract extraction.
>
> Crawford Long of Jefferson, Georgia, probably was the first to use ether for anesthesia, but failed to report it. Morton, a Boston dentist, rediscovered it and this was reported (by him) in the literature.
>
> Dr. Ben Jenkins of Georgia began using alpha-chymotrypsin for zonulolysis in 1955. An attempt to clear vitreous opacities in a congenitally blind eye was unsuccessful, but the enzyme did cause the lens to dislocate. Jenkins then routinely used the enzyme for cataract extraction but failed to report it in the literature.
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> Two years later, Dr. Joaquin Barraquer (of Barcelona, Spain) made a similar observation. With the hope of dissolving a vitreous hemorrhage he injected alpha-chymotrypsin into an eye. No effect was noted on the hemorrhage, but the lens dislocated and Barraquer began using it in his cataract cases. He reported it in the literature in 1958.

Undoubtedly Barraquer and Jenkins will go down in history as co-discoverers of alpha-chymotrypsin as a zonulolytic agent just as Morton and Long were the co-discoverers of ether as an anesthetic agent. We will let the historians wrangle over priorities.

The clearest concept of what the enzyme does to the zonules has been offered by Ley and associates.[3] They employed light and the electron microscope to show that the enzyme apparently lysed certain segmental zones across the zonular fiber so that it was fragmented into many short sections. Just how these segmented zones differ from the rest of the fiber is yet to be elucidated.

Barraquer,[1] in his original report, stated that the enzyme has a specific action on the zonule and nothing else. There are numerous references in the literature that cast doubt on the "specific action." Lytic action on the vitreous body and retina have been reported. Many feel very definitely that wound healing is delayed and that catgut sutures are dissolved more quickly when it is used. On the other side of the fence are those firmly denying these allegations. Whatever its action, all agree that it facilitates lens extraction and, when used as indicated, minimizes complications and gives a higher percentage of intracapsular extractions.

There are several products on the market at the present time which all seem to be equally effective. The author personally could not tell when any particular product was used either in its effectiveness or

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after-effects. The main concern has been in its sterility and freedom from foreign matter. A tendency has been noted for operating room personnel to handle the vial containing the diluent in the same non-sterile manner used for extracting local anesthetic agents and so forth. They simply wipe off the glass vial or rubber stopper with an alcohol sponge before breaking the neck of the vial or inserting the needle to withdraw the diluent. These vials should be soaked in the surgeon's favorite sterilizing solution used to sterilize sharp instruments, then the vial should be considered a sterile container.

A difference of opinion still exists as to when trypsin should and should not be used, and it must be admitted that sufficient time has not elapsed for firm opinions to be formulated. In an attempt to arrive at some conclusions in this regard, the investigator used alpha-chymotrypsin routinely for 224 cataract extractions. When the series ended, certain impressions were evident, the foremost of which was that it was not indicated in routine cataract extractions and second, that residents should not use it until they have familiarized themselves with usual techniques.

The youngest patient in which alpha-chymotrypsin was used in the series was 25 years old. The author and his associates, as well as others, feel that cataract extraction in those patients between twenty-five and sixty years of age is more easily executed and with a higher percentage of intact capsules than without it. Beyond sixty years of age it could not be said with any certainty that alpha-chymotrypsin was of any additional value. Since most cataracts are removed in individuals over sixty years of age, its use now is infrequent. There is so much variation in the resistance offered by the zonule in those of sixty years and over that, in the investigator's area, trypsin is being used in this age group only if the first eye has tough zonule.

Intumescent and hypermature cataracts have always been difficult for the author to extract with forceps; frequently the capsule is broken even with the erisophake. It was found that alpha-chymotrypsin made the extraction in both entities easier with a higher percentage of intact capsules.

Alpha-chymotrypsin is avoided in cases where hypotony is not obtained by retrobulbar injection, because the lens so often becomes spherical and practically delivers itself expulsively in these cases. This product is not utilized in high myopia, postoperative retinal separation, uveitis and traumatic luxation of the lens with vitreous face ruptured, because of the suspicion that the vitreous is more or less fluid in these cases. The author and his associates have not had enough experience with the luxated lens of Marfan's syndrome to give a firm opinion. It is believed, however, that the possibilities of complications are greater when the enzyme is not used.

It is the opinion of the investigator and associates that preliminary needling followed by linear extraction to be the safest technique under 25 years of age. It is true that by this method two and sometimes three operations are required to get the final visual result, but the author as yet cannot forget the movie presented at the Academy by Richard Troutman two years ago showing the attachment of the vitreous to the posterior surface of the lens and the extraction of both when alpha-chymotrypsin was used in this young age group.

From the author's series of alpha-chymotrypsin extractions, it was learned that new techniques had to be acquired. It was noted that although it made the delivery of the lens easier, the author still had to use the products of experience with regular lens extraction (particularly that of the luxated lens) to do an effective job. It was because of this need for judgment and skill acquired by experience that it was decided that the residents should not start out using this product, but its use was limited to the latter part of their surgical training and then only in selected cases.

It was found necessary to have a widely dilated pupil and if this could not be acquired by injecting epinephrine (1/1000) in the sub-Tenon' space about the limbus and instillation into the anterior chamber, a sphincterotomy would be done above. The author can see no need to do a broad based complete iridectomy in the non-complicated eye.

There is a difference of opinion as to whether 1/5000 or 1/10,000 dilution of alpha-chymotrypsin is most desirable. Except for the first fifteen eyes in the author's series, a 1/10,000 dilution was utilized and left in contact with the zonule for three minutes before the chamber was irrigated with saline.

The amount of trypsin injected into the posterior chamber varies with different authors. The posterior chamber holds only 0.3-0.5 ml. of aqueous, and it is the investigator's practice to inject through the peripheral coloboma above until the iris balloons forward and the solution then comes out of the incision; it is then known that there is trypsin in all parts of the posterior chamber. Some surgeons feel that by injecting through the pupil and into the lower half of

the posterior chamber they are able to cause lysis of the lower zonule only and thus reserve the upper zonule intact as a hinge for tumbling. This sounds good in theory but in practice it is difficult to control the area of zonulolysis by this method. Hill[4] advises Kato's[5] method of injecting only two drops of alpha-chymotrypsin below if you intend to retain a hinge of zonule above for tumbling.

Tumbling of the lens is dangerous unless the zonular attachments are retained above. The sliding technique is certainly indicated with full luxation of the lens. There is a strong tendency for the lens to assume a spherical shape and to push forward with the iris rather snugly against the cornea. This tendency is less when the degree of sclerosis present is greater. When the lens assumes a spherical shape it was found difficult to grasp the capsule with the capsule forceps and the erisophake had to be used.

The forward position of the lens makes it difficult and dangerous to get even the erisophake on the capsule below for tumbling without injuring the corneal endothelium. Murphy[6] attempts to correct this handicap by applying the erisophake immediately after injecting the enzyme and holding it there for the three minutes needed to effect zonulolysis. The author has not tried this method, but it sounds as if it would be necessary to pre-guess which lens was going to come forward to make this seemingly clumsy maneuver necessary. The author could hardly see himself hanging onto an erisophake for three minutes. There are too many times when the Bell erisophake loses its grasp, also too much opportunity for accidental movement on the part of the patient or surgeon during this waiting period.

The forward position of the spherical lens, when it occurs, is an indication for the surgeon to slide the lens out by pressure below and possibly a flat spatula above, very similar to the old Smith-Indian technique. No instrument is applied to the lens itself. When the lens doesn't come forward strongly, the cornea can be picked up and erisophake applied above and lens slid out.

In the literature are recurring references to impressions that alpha-chymotrypsin caused: (1) Catgut sutures to dissolve more quickly; the author's group did not find this to be true; (2) that wound healing was delayed and therefore indicated the use of at least five corneoscleral sutures, preferably silk. The author and associates have not found any evidence of delayed wound healing or the need for more than three gut corneoscleral sutures; (3) that alpha-chymotrypsin should not be utilized if there is endothelial corneal dystrophy. The author personally feels that endothelial corneal dystrophy is one of the indications for alpha-chymotrypsin, since its use makes the lens delivery less traumatic and anything which will do this will be less damaging to already damaged tissues. Certainly, there was no evidence that the enzyme was producing corneal edema or damage. Hill[4] noted less striate keratitis with the use of alpha-chymotrypsin—another indication that the cornea is treated more gently by its use, especially when the sliding technique is used. Admittedly, the tumbling technique should not be utilized in any case of corneal dystrophy whether trypsin is used or not.

The author's group is now collecting data in the hope that some information will evolve referable to the incidence of anterior hyaloid rupture at operation or at various times postoperatively in an effort to see whether trypsin has any influence in its production. A similar interest in postoperative retinal separation is being exhibited in this regard but the information is not yet available. In both conditions there are so many other factors involved in their production that an answer may not be forthcoming.

Iris pigment epithelium fragmentation with liberation of black pigment in the aqueous almost immediately with the injection of alpha-chymotrypsin has been noted by Kara.[7] The author has not been able to relate this to the injection and yet it does occur with or without trypsin in cases of iris atrophy, notably in association with diabetes. It is prone to be deposited on the corneal endothelium and often is not seen, especially in the pupil area, until the chamber is filled with air or saline. Most certainly the only time that it can be removed is at the time of its deposition and this by irrigation.

The author has not seen corneal edema with alpha-chymotrypsin as reported by Kara.[7] The latter, however, stated that he saw corneal edema and pigment epithelium fragmentation mostly with the Spanish product (Penya). This product was used exclusively by the author's group until the Armour product became available. Murphy[6] also noted marked corneal edema and striate keratitis with alpha-chymotrypsin, but it cleared in most cases in ten days but persisted in a few others for four weeks. He used 1/5000 dilution which might be a contributing factor. He also reported more vitreous loss, iris prolapse, hyphemia, retinal separation and endophthalmitis than in a similar series when trypsin was not used. The series of the author and his associates does not sub-

stantiate these serious objections to its use. On the plus side, Murphy[6] found less frequently loss of anterior chamber and fewer ruptured capsules with alpha-chymotrypsin. The latter finding is almost universally noted in reported series.

What, then, can be said referable to experience with alpha-chymotrypsin by the author and his associates?

1. Reserve the enzyme for those eyes in which difficulty is anticipated in getting an intracapsular extraction in the 25-60 year old group.

2. A preliminary needling followed by linear extraction is as yet preferable to alpha-chymotrypsin in the age group under 25 years; over 60 years of age there is little if any help obtained from trypsin.

3. It is necessary to learn to use an erisophake as it is more frequently needed with alpha-chymotrypsin than without.

4. The sliding technique is the least traumatic with alpha-chymotrypsin.

5. Alpha-chymotrypsin is advisable in intumescent and hypermature lenses and in cases of exfoliation of the lens capsule, in all of which capsules are prone to rupture.

6. Alpha-chymotrypsin is indicated, in the investigator's opinion, in endothelial corneal dystrophy along with the sliding technique as the least traumatic operation possible.

7. Alpha-chymotrypsin is helpful in traumatic and congenital luxation of lens with intact hyaloid.

8. Alpha-chymotrypsin is contraindicated in luxated lenses with vitreous face ruptured and in cases of known or suspected fluid vitreous.

9. *Amen* is said to P. J. Kennedy's statement[8]:

Although trypsin is a valuable aid in obtaining an intracapsular extraction—in certain instances, its use does not minimize the knowledge, skill and manual dexterity which are necessary for good surgery.

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Hospital Construction Report

Last year in the United States an average of $2.7 million a day was spent on the construction of hospitals, nursing homes and other health facilities.

A total of $978 million was expended on such construction during 1960, based on statistics supplied by the U.S. Department of Commerce.

The past five years were a peak period for hospital construction. From 1956 through 1960, expenditures on new construction of hospitals, nursing homes and other health facilities amounted to $4,467,000,000, compared to $3,866,000,000 for the preceding five-year period.

Other government analyses have shown that private sources now provide the major portion of the funds for this construction.

In 1940, total hospital construction expenditures were $87 million of which $33 million, or 38 per cent of the total, came from private sources. However, in 1960, private construction amounted to $579 million, or 59 per cent of the year's total of $978 million.

Contact Lenses and the Medical Profession

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THE FIRST CONTACT LENSES were developed by medical practitioners. These were made of glass and used for corneal astigmatism. These lenses were extremely uncomfortable, causing pain and corneal edema after several hours of wearing. Over a period of years the lenses evolved from a molded scleral shell with fluid filling the space between cornea and lens to a lens allowing tear interchange between the cul de sacs and lens by holes made in the lens; finally evolving to the various types of small corneal lenses utilized today. Most of the advances made were due to the utilization of monomer-polymer mixes or polymethyl methacrylates which are clear, relatively inert when properly treated, and easy to work.

Actually, much of the evolution from scleral to corneal lens was a result of work by lay individuals or groups. Their primary purpose was to develop a lens utilizable to larger, non-medically oriented people; in other words, a lens which could be worn by individuals who desired only such cosmetic improvement as could be achieved by discarding spectacles.

The development of the corneal lens was accompanied by flamboyant advertising in the public press which readily drowned out the disclaiming cries of the medical profession.

From the time of the introduction of corneal contact lenses (at the end of World War II), to the present there have been serious objections to the indiscriminate wearing of contact lenses by the general public. In essence, the medical objections are as follows:

Lack of Understanding of Corneal Metabolism.—To this day practically nothing is known of the corneal function with a contact lens (of any type) in place.

Lack of Uniformity of Standards and Nomenclature.—There are many manufacturers of contact lenses, each claiming their product is best. The lack of uniformity in discussing details of structure, nomenclature, and even units of measurements, e.g., millimeters vs. inches, is appalling.

Materials.—The standard material used in the manufacture of contact lenses is methyl methacrylate. This substance is a monomer-polymer mix and can be severely irritating to living tissue generally depending upon the amount of monomer left in the stock used for grinding the lens. Naturally, the stock varies with the manufacturer. Methacrylates are also notable in their porosity and hygroscopic action. Both features tend to increase the irritability of the finished lens by causing stickiness of the lens to the tissues and by washing more of the monomer out of the lens as well as taking on fluids, either of which are not easily tolerated by ocular tissues. The easily scratched surface of this plastic is another feature which reduces the functional characteristics of these lenses.

Medical Ethics and Understanding.—This is the area where the gentlemanly relationships between the medical profession and various lay groups may be strained to the breaking point.

Advertising in the public press.

Failure to evaluate the potential contact lens wearer from a medical point of view: The contact lens is a prosthetic device. Unless the patient is carefully evaluated from a medical point of view as to the need of contact lenses or their desirability, serious ophthalmologic disease, such as glaucoma, may be overlooked.

Use of drugs: It is a matter of public law that drugs are a province of medical practice. Yet it is also known that various lay practitioners of contact lens fitting are routinely using such drugs as fluorescein and local anesthetics without medical supervi-

sion. As a matter of fact, contact lenses can not be fitted without using drugs.

Diagnosis and treatment of medical complications of contact lenses: The increasing popularity of contact lenses naturally has increased the complications which can occur as a result of their use. The reasons for this are obvious: lack of suitability; improper fit; lack of knowledge of corneal metabolism; poor training of the patient as to insertion, removal, hygiene and wearing time; secondary trauma; infection; lack of supervision; etc.

If medical care is not readily available, permanent damage to the cornea, and possibly the globe, may result.

Increasing knowledge of medical uses for contact lenses: The use of contact lenses as a substitute for spectacles is of secondary importance to the practicing physician. Knowledge of the medical importance of contact lenses in the care and treatment of various ocular and corneal diseases is growing daily. Much of this gain is the result of perfection of a special molded scleral contact lens by Ridley. This lens may be used for severe keratoconus, recurrent corneal erosion, symblepharon and scarring from chemical burn, Stevens-Johnson's disease, et cetera. Corneal lenses may be fitted over the aphakic eye, or the post corneal transplant astigmatism lenses may be utilized to cover iris deficiencies for increased visual efficiency or even to improve the cosmetic appearance of a quiescent but disfigured eye; even a microphthalmic eye may be covered. A contact shell may be used over an eviscerated globe with impunity.

Recently, a bill (House Bill No. 574) was passed by the state legislature which in essence allows licensed optometrists to practice fitting contact lenses, even with the knowledge of that which has been discussed heretofore. The bill passed in spite of objections raised by responsible members of the ophthalmologic specialty group of this state (including the chairmen of the respective departments of ophthalmology of both medical schools in the state). The bill passed practically without objection in either house or senate. The primary (and successful) argument of the lay group involved pertained to their longstanding utilization of contact lenses and advancements in the field. All this in spite of the arguments noted above. The basic problem as to who is responsible for the medical problems involved is of course unanswered.

How can the safety of the public be properly maintained and real knowledge gained in the medical use of contact lenses?

At Wayne State University College of Medicine a separate division of Ophthalmic Prosthetics has been set up under the Department of Ophthalmology. The purposes of this unit is as follows:

1. Proper training of resident personnel in the utilization of various ophthalmic prosthetics. A separate clinic is set up for this purpose, and shall include medical supervision in the fitting and wearing of contact lenses.
2. Statistical evaluation of various characteristics noted to be of value or hazard in various lens types and structures. This is to be accomplished by adequate data maintenance and processing.
3. Cooperation with various other university groups in the development of new materials, products, and methods.
4. Utilization of proper nomenclature and evaluation in the determination of proper qualities for contact lenses.
5. Basic research into the metabolism of the globe when prosthetics are utilized.
6. Dissemination of knowledge to postgraduates interested in the utilization of various ophthalmic prosthetics.

In the final analysis, the proper usage of prosthetic devices pertaining to the globe would appear to be a prerogative of the medical practitioner. Whether the medical profession can maintain this prerogative is a function of understanding, interest, and progress.

Medical Indications and Contraindications For Contact Lenses

Certain individuals may adapt themselves well to the corneal contact lens while others may require the full scleral or molded lens as popularized and perfected by Ridley.

Before attempting any actual fitting of contact lenses, one should have a pretty good idea of the patient's capabilities, structurally, physically, and psychically.

Indications.—

1. The primary requirement and indication for contact lens wearing is *desire*. The patient should not be "sold" contact lenses. The possible advantages and disabilities incurred in the wearing of lenses should be explained fully before the patient enters into the actual trial fitting. Many patients will be seen who desire only to get rid of their glasses. If the glasses are adequately fitted and the patient is having no difficulty with them, he (or she) should be carefully questioned as to his real need or demand for the lenses. There is little if any value to carrying out the demands in time and effort for proper contact lens

fitting to have the patient put them in a drawer and forget about them.

2. *Cosmosis:* Many patients will come to the ophthalmologist for contact lenses for cosmetic reasons alone. Actually most of such patients are probably seen by an optometrist because the patient is aware of no true visual difficulty. These patients are not the best contact lens wearers and again careful interrogation is necessary to determine the true need or desire for the lenses. The patient who feels a real cosmetic need for lenses will wear them successfully.

3. *High refractive error:* As long as the individual has no real binocular imbalance and has a notably good fusion range, contact lenses can be considered in the myope, astigmat, and the hypermetrope. The moderately high myope ($>$ —2.50) will be extremely gratified in the wearing of lenses for they will not only have a bigger visual field but will be able to see more efficiently than with the use of spectacles. This is also true of an individual with moderate to high astigmatism and will be considered further in the evaluation of an individual having keratoconus. The hypermetrope may also be comfortable with contact lenses, but this group often has a related muscle imbalance and great care must be made to properly interpret the binocular status of the individual before fitting. In the group of refractive errors who are benefited by contact lenses one must include anisometropia, for an individual with an anisometropia will be truly benefited with properly fitting contact lenses.

4. *Occupational:* Certain individuals will find the wearing of spectacles unsuitable to their particular occupation. Telephone linemen, models, receptionists, salespeople, athletes and others who are in constant contact with the public or in those occupations where spectacles might be considered a hazard such as athletics, find true benefit in the wearing of contact lenses.

5. *Keratoconus:* Actually keratoconus should be considered under high refractive errors but it must be placed in a separate grouping because this is one which must be carefully considered from every point of view before actual fitting is considered. Keratoconus may be a progressive disease in young people. Under such circumstances the wearing of a contact lens must be controlled carefully by the physician. Difficulty in maintaining a proper fit may be an indication of change in corneal curvature. In a low grade of keratoconus a corneal lens might be worn, but when the keratoconus reaches a stage of central corneal thinning with scarring it may be necessary to utilize the molded Ridley type lens. Any case of keratoconus requires careful medical evaluation, including a complete allergic workup.

6. *Aphakia:* Both binocular and monocular aphakes handle contact lenses with relative ease and visual benefit. Their visual field is not only larger, but they would appear to maintain binocularity and have reasonable comfort. The lenses can be utilized through the complete working day.

7. *Corneal transplants:* It is not uncommon to find an individual who has a successful corneal transplant but who is unable to attain normal visual function because of severe refractive error following surgery. These individuals are able to wear contact lenses with comfort and visual improvement.

8. *Corneal scarring:* Small central corneal scars, inactive herpetic lesions as caused by trauma, inactive herpes may be benefited by a corneal lens. In some cases the lens may require a filter to properly reduce diffraction from the area of corneal scar. In many cases, however, contact lenses can be worn with improvement of vision. The corneal scarring of interstitial keratitis is occasionally benefited by contact lenses.

9. *Chemical burns:* It has been our experience that an occasional individual with severe chemical burns or recurrent corneal erosion from an old chemical burn can wear a scleral type molded lens with impunity and improvement in vision.

10. *Pupillary abnormalities:* The individual with an iridodialysis or visually debilitating iris lesion may wear a contact lens which has been colored to match the iris shade and get return of normal visual function.

11. *Nystagmus:* Some patients with nystagmus can wear contact lenses with great improvement in vision.

Contraindications.—

1. *Previously poorly fitted contact lenses:* The individual who comes under your care who has had or is wearing poorly fitting contact lenses may have entered into an abnormal corneal metabolic condition.

There may be recurrent corneal erosion, hypoanesthesia or anesthesia of the cornea. Real structural changes may evolve which persist even after the lenses are removed. These individuals may not be able to wear even properly fitted lenses thereafter.

2. *Muscle Imbalance:* Any muscle imbalance whether it be vertical or horizontal (meaning exophoria or esophoria) should be considered a poor risk for contact lenses and the patient should be carefully instructed as to the poor prognosis and potential wearability. A patient with reduced extra-ocular movement in any direction is not a good candidate for contact lenses.

3. *Photophobia:* The individual who has photophobia due to diminished iris coloration or partial albinism may be able to wear contact lenses. However, the individual who has unexplained photophobia and has a chronic blepharospasm is a bad candidate for contacts.

4. The individual with *ocular allergy* is a bad contact lens patient and should be deferred if possible.

5. The individual with *chronic inflammation of the lid* whether it be from a chronic staph infection or seborrhea not controlled should not be considered for contact lens wearing.

6. The individual with *chronic recurrent inflammation of the iris* or anterior segment should not be considered for contact lens wearing.

7. The individual with *chronic tearing or with keratitis sicca* should not be considered for contact lens wearing.

8. The individual with *chronic or recurrent erosion of the cornea* is a poor contact lens candidate unless the reason for the recurrent erosion can be brought under control.

9. An individual with *chronic glaucoma* is not a good candidate for contact lenses. As a matter of fact, some of the symptoms of chronic glaucoma can be obtained by individuals wearing improperly fitted contact lenses. For instance, a too tight lens may cause corneal edema with halo vision and light sensitivity.

10. *Endothelial dystrophy.*

11. A patient with *exophthalmos or lid retraction* probably is not a candidate for contact lenses; however, in some cases the Ridley type lens might be indicated if real control of the corneal surface can not be attained. For this reason some patients with old Stevens-Johnson's disease might wear a Ridley type contact lens, also those with trichosis due to scarring of the lids. The most important point, of course, is the proper evaluation of the patient from the point of view of structure, desire, mental attitude and type of lens.

1553 Woodward Avenue

Recommendations Re Mental Health

A shortened medical curriculum and more medical schools have been recommended by the president of the American Psychiatric Association in attacking the nation's great mental health problem.

"The manpower situation in psychiatry and all related disciplines dealing with mental illness is woefully inadequate," said Dr. Walter E. Barton. "We are not even reproducing our annual manpower losses in this field."

In his specific recommendations, Doctor Barton advocated that the medical training program be shortened and condensed from its present eight years to six years.

He declared that the nation needs at least twenty more medical schools in the very near future to help erase the increasingly critical shortage of physicians. Doctor Barton recommended liberalizing of the examinations and restrictions now placed against foreign-trained doctors which prevent them from practicing medicine and psychiatry in the United States.

He advised greater use of "part-time physicians," psychiatrists who have left mental hospitals for private practice but who still can be retained for part-time work in the mental wards.

The Surgery of Deafness

III. Tympanoplasty

Brian F. McCabe, M.D.

Ann Arbor, Michigan

THE AIM of the ear surgeon in the treatment of suppurative ear disease has been for many decades chiefly the elimination of infection from an involved temporal bone. Another aspect of mastoid surgery has now assumed an importance such that it is today an integral part of almost each operation done for chronic suppurative otitis media and mastoiditis. This new part of the operation is termed tympanoplasty. In it the salvageable remnants of the conductive mechanism of the ear are reconstituted so as to restore hearing.

The idea that otologists still perform mastoidectomies often puzzles the average physician, who assumed long ago that the era of antibiotics had sounded the death knell of suppurative mastoid disease, and with it, otolaryngology. Nothing could be farther from the truth. Antibiotics and antimicrobials forced the microbe kingdom to loosen its grip on the vertebrate-kingdom in allaying the early ravages of many acute infections; the former answered this challenge by clamping a new hold on the latter in the form of insidious chronic infections. This is demonstrated graphically by comparing the decline in the number of mastoidectomies done for acute infection over the past two decades with the rise in the number of those done for chronic mastoiditis. Whereas operations for acute disease have become uncommon, operations for chronic disease have become so frequent in incidence that they may soon equal in number the former.

That this should be so is only partly the fault of the antibiotics; it is also partly our fault. The majority of patients operated upon for chronic mastoiditis in the past five years were raised in the antibiotic era. It is self-evident that chronic mastoiditis can only have its origin in an unresolved acute otitis media. The increase in chronic mastoiditis, then, can only mean that there is an increase in the number of unresolved acute middle ear infections, undoubtedly because of injudicious use of antibiotics, inadequate followup, and the lamentable abandonment of the myringotomy knife by practitioners of medicine. Merely the cessation of pain or otorrhea does not herald the conquest of the infection. Treatment must continue until the tympanic membrane is normal and the middle ear air-containing or the upswinging curve of chronic mastoiditis will never peak.

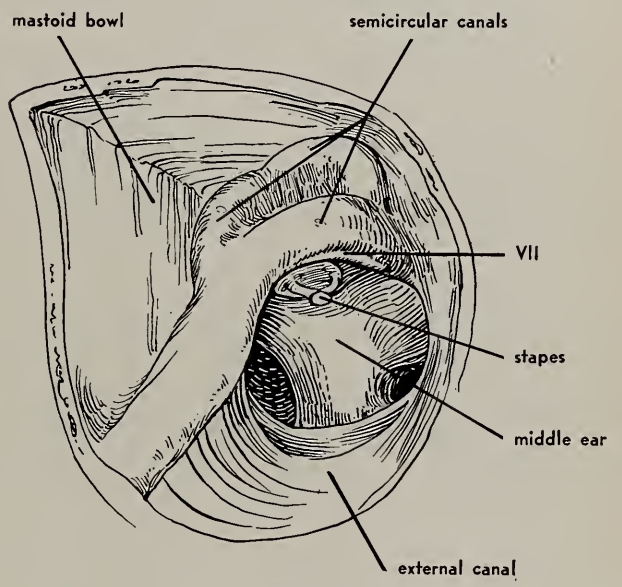


Fig. 1. The radical mastoidectomy. In it, the external canal becomes joined with the sculptured mastoid cavity. The middle ear is removed in all but its mesial wall and the common chamber becomes lined with skin.

The operation done for acute mastoiditis is essentially the drainage of a mastoid abscess, with sequestrectomy of necrotic mastoid cell walls, postauricular drainage, and (at least prior to antibiotic therapy) healing by secondary intention. It is done for acute osteomyelitis when the disease does not respond to antibiotics. Mastoid surgery for chronic osteomyelitis is however, an entirely different story. The chronic process does not respond to antibiotics and the treatment is always surgical. The surgery of chronic osteomyelitis is similar to the surgery of neoplasia, in that every minute remnant of the disease

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process must be eliminated to guarantee against recurrence. The process further is usually complicated by the presence of cholesteatoma, which also recurs unless scrupulously excised. This double operative burden carried out within the narrow confines of a

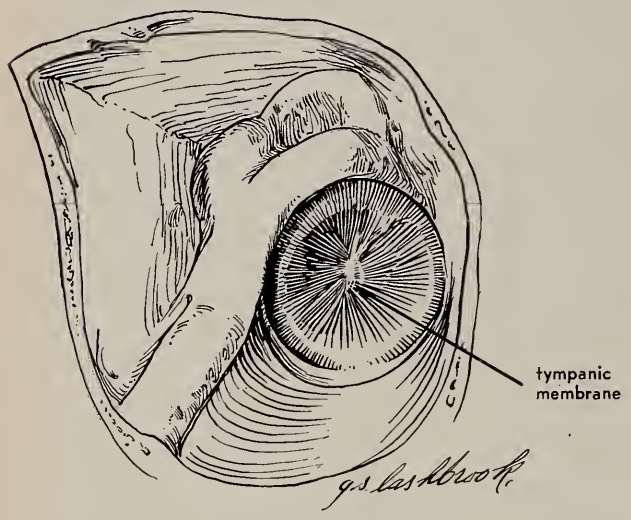


Fig. 2. The modified radical mastoidectomy. The middle ear is preserved, separate from the common chamber of external canal and mastoid bowl. The success of this operation in preserving hearing stimulated the development of tympanoplasty.

host of vital structures—cerebellum, facial nerve, cerebrum, sigmoid sinus, vestibular labyrinth, jugular bulb, and cochlea, make of the radical mastoidectomy not the simple curettage of a half-ounce of bone but a virtual sculpturing of an angular chamber leaving in bold relief thin bony plates over the brain and inner ear.

The radical mastoid operation is in essence a conversion of the mastoid and middle ear cavities into a common chamber with the external auditory canal, with the sacrifice of any remnants of tympanic membrane or ossicles which resisted the disease process. This cavity becomes lined with skin growing in from the canal opening. It seemed unnecessary to early ear surgeons to sacrifice the middle ear, and hence hearing, when this chamber was largely undiseased, and so a great step was taken in the evolution of mastoidectomy: the preservation of the middle ear and conversion of the mastoid cavity and external canal to one chamber. This election possible in some cases came to be known as a modified radical mastoidectomy.

The next step in evolution came about through the efforts of pioneering ear surgeons such as Wullstein and Zollner to preserve hearing even in cases where the middle ear was greatly impaired by disease.

Tympanoplasty has as its objectives the elimination of irreversibly diseased tissue, and the preservation of normal and reversibly diseased tissue important in the conduction of sound pressure to the inner ear. It is obviously an election not possible in every case of chronic mastoiditis, for example it is pointless to take great pains in preserving the middle ear when a coexisting perceptive deafness makes serviceable hearing unattainable. This is probably an absolute contraindication to tympanoplasty; there are also relative contraindications such as cicatricial stenosis of the

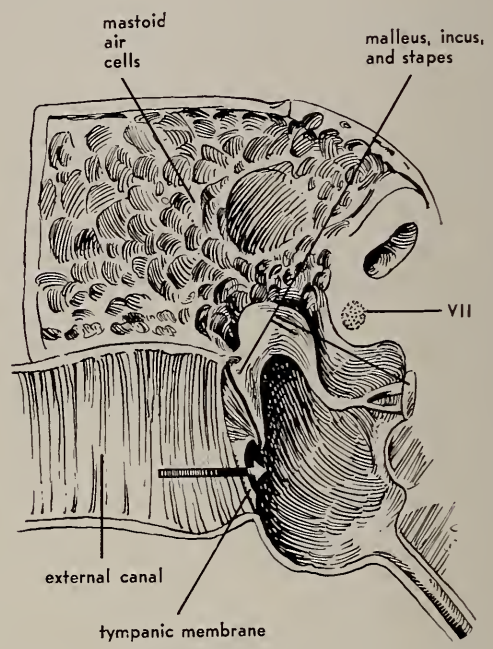


Fig. 3. *Tympanoplasty Type I:* this is basically a myringoplasty, or closure of an existing perforation. Arrow indicates perforation.

eustachian tube, neoplasm, and cholesteatosis of the middle ear. In these cases it may be prudent or necessary to perform a radical mastoidectomy.

Thus it is inadvisable to do a tympanoplasty each time a mastoidectomy is done. As long as chronic osteitis and osteomyelitis of the temporal bone remain surgical diseases, the classical radical mastoidectomy will never perish.

In those cases however where salvage of the middle ear is feasible, tympanoplasty today offers a greater chance than ever before of not only eliminating the life-threatening complications of mastoiditis but of restoring the ear to usefulness.

The variations of technique in tympanoplasty are determined by how much of the middle ear is left after the excisive part of the operation. These varia-

tions are not completely standardized and perhaps never should be, but a number of variations have been developed by Wullstein, which have gained such wide acceptance that no discussion of tympanoplasty is complete without a résumé of them.

Type I. This is essentially a myringoplasty or restoration of the continuity of the tympanic membrane. A mastoidectomy is not done, but certain measures are usually carried out to ensure the safety of the procedure. In event of a marginal perforation for example, it is necessary to exclude the possibility of

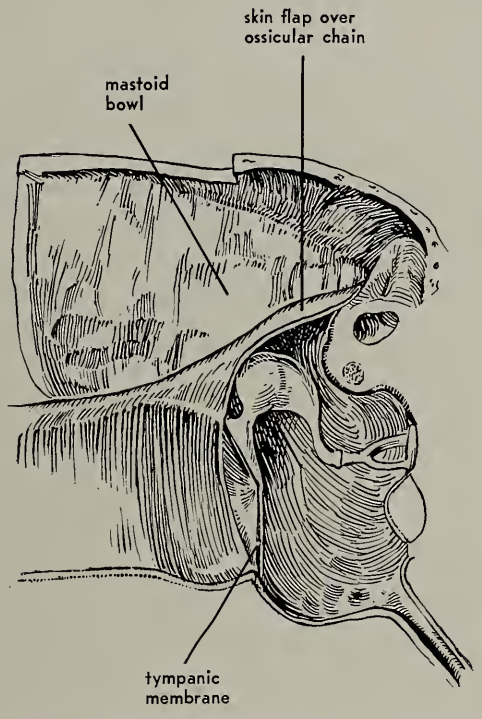


Fig. 4. *Tympanoplasty Type II:* the mastoid bowl and external canal are converted to one chamber, but the entire ossicular chain and middle ear are retained under a skin flap.

cholesteatoma in the mastoid antrum or tympanic attic. It may only be carried out when the middle ear is absolutely free of suppuration or mucorrhea. Wullstein and other Europeans advocate the use of a full-thickness post-auricular free skin graft to close the perforation, but American otologists now prefer vein wall tissue, canal wall pedicle or free grafts, or a combination of these.

Type II. A mastoidectomy is performed and this cavity is made confluent with the external canal but the ossicular chain is left intact. A free full thickness graft is used to cover any exposed portion of the ossicular chain and close the existing perforation. It is indicated in relatively few cases and should not be performed where cholesteatoma involves the tympanic attic. In this event the chances of incomplete cholesteatome removal, e.g., from the mesial surface of the body of the incus, are high.

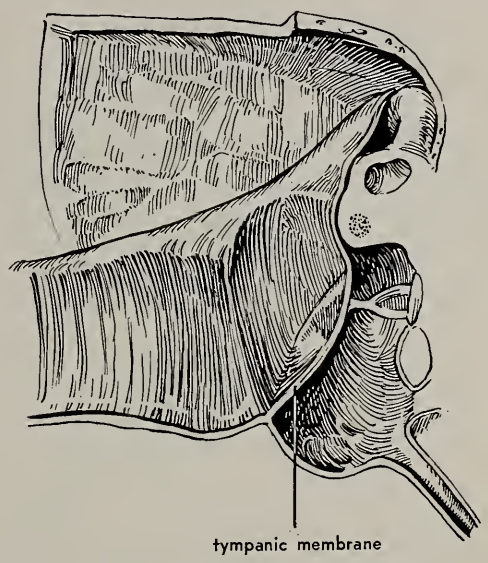


Fig. 5. *Tympanoplasty Type III:* when the incus is diseased and requires removal, the tympanic membrane may be titled inward to rest against the stapes.

Type III. This variety of tympanoplasty is identical to the modified radical mastoidectomy when the viable tympanomeatal flap is used. The tympanic membrane is tilted inward and brought in contact with the stapes. The incus and malleus are removed, or the malleus handle alone may be left behind. Where the perforation is wide, a free graft may be used as described by Wullstein, but a sliding bipedicle or monopedicle has many advantages over a free graft (cf. The Surgery of Deafness I, in this series). Canal flaps, free canal skin, and vein wall are proving so far superior to extra-auricular skin that few ear surgeons now advocate the use of the latter.

In all the above types, normal hearing may be attainable when the hearing loss is of middle ear origin. In each type, reconstructive measures are adequate to produce sound pressure levels at the stapedial footplate similar to those in the normal ear.

Type IV. Where the stapedial crura are absent through disease, no remaining part of the ossicular chain can be used in the reconstruction. In this type, the footplate of the stapes is open to the large common chamber and a lower-half middle ear is created joining the round window and eustachian tube orifice. This

inferior air chamber ("cavum minor") provides sound insulation to the round window so that ararefaction wave arrives at the round window membrane at the time a compression wave strikes the stapedial footplate. This favors basilar membrane deflection in the inner

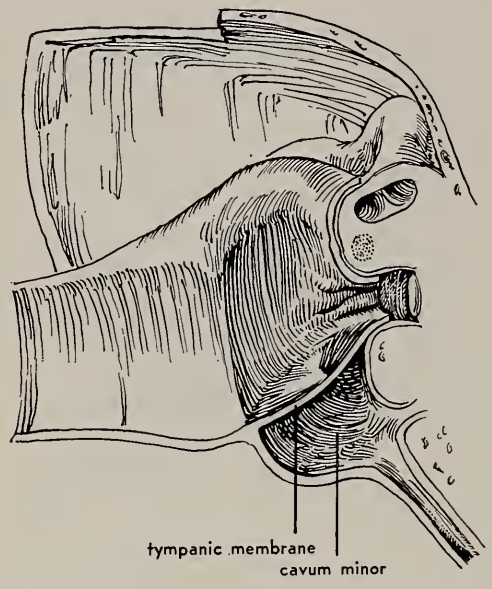


Fig. 6. *Tympanoplasty Type IV:* with the entire ossicular chain destroyed, serviceable hearing may be achieved by providing sound protection to the round window.

ear, and hence, hearing. But without the favorable areal ration between tympanic membrane and stapedial footplate as in types I-III, hearing suffers, and the best level that can be expected in the type IV tympanoplasty is 26 db. Although not normal, this hearing is serviceable and is better than the 45 db to 60 db the radical mastoidectomy usually affords.

Wullstein also describes a fifth type which is seldom performed today. It is designed to meet the condition of a fixed footplate, and is a combination of a type IV tympanoplasty and the classical fenestration operation. Unless the middle ear and mastoid are completely free of suppuration, it is performed in two stages. With the advent of newer techniques, it is, like the fenestration operation, passing into relative obscurity.

It is readily apparent there is not much which is startlingly new in the four or five types of tympanoplasty. Type I has been known for generations as a myringoplasty, and type III as a modified radical mastoidectomy. Types II and IV represent newer concepts of middle ear reconstruction but type II is technically no easier than modified radical mastoidectomy while producing the same expected hearing result, and type IV is most remarkable only in its inability to produce a satisfactorily high rate of serviceable hearing in spite of its soundess physiologically. However, there is no question of the fact that Wullstein has done otolaryngology a great service in his logical organization of this subject material and his reassessment of the possibilities of conservatisim in tympanic surgery.

As alluded to, the type IV tympanoplasty produces the most disappointing results in restoration of hearing. In our series, only 25 per cent of those patients

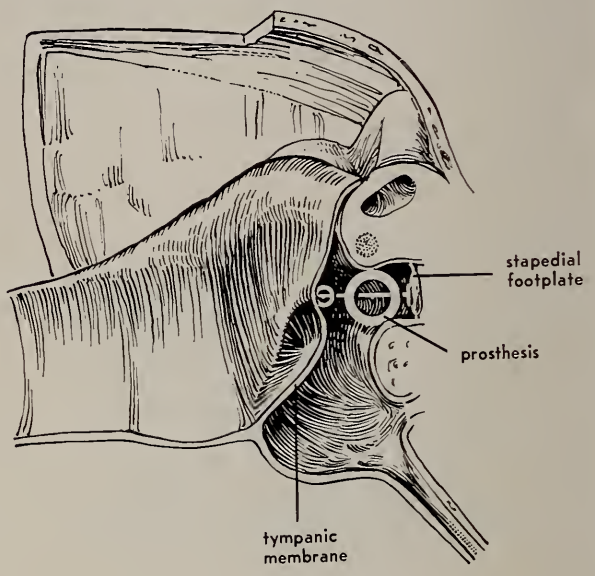


Fig. 7. A *Type IV Tympanoplasty* may be converted to a *Type III* by the employment of a polyethylene-stainless steel prosthesis. The foot of the steel columella rests against the footplate of the stapes. It is stabilized by a length of polyethylene 190 tubing, resting securely in the oval window niche. An end-button of smaller polyethylene prevents its piercing through the tympanic membrane.

in whom this procedure was the only election surpassed the 30 db line on their last audiogram. This experience does not differ greatly from other reported series of type IV tympanoplasties in this country. This is not unreasonable in this operation as designed if one considers the numerous possible causes for failure. It must be realized that the theoretical highest attainable hearing level in this operation is 26 db. If the suppurative process in the middle ear and mastoid has been extensive enough to produce necrosis of the stapedial crura, extensive albeit reversible inflammation of the tympanic mucosa takes place by contiguity. As this suppurative inflammation subsides, subepithelial fibrosis can be expected to occur as part of the healing process. This fibrosis maturing to cicatrization can involve the key points in the middle ear as well as elsewhere, and when it occurs

in normally highly supple structures such as the round window membrane or stapediovestibular ligament, some depreciation of response to sound pressure can be expected. If this attenuation amounts to only 10 db, the hoped-for hearing level of 30 db cannot be reached.

The most logical solution to this dilemma is to provide in the operative technique a mechanism whereby sound pressure at the stapedial footplate can be increased. In the type IV tympanoplasty, the tympanic membrane is utilized to provide only sound protection to the round window. By recruiting it to do also its prior job of gathering sound pressure for

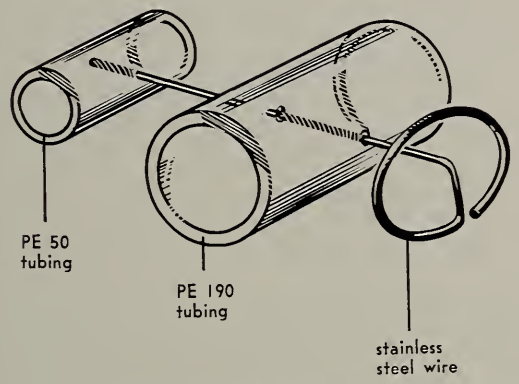


Fig. 8. The composite prosthesis. The steel columella slides freely through the PE 190 stabilizer.

delivery to the footplate, this objective would be reached. By restoring the areal ratio of tympanic membrane to footplate, even normal hearing would be attainable.

This can be accomplished by restoring the full height of the mesotympanum and connecting the tympanic membrane to the footplate across the air chamber. The direct connection by polyethylene between the footplate and the malleus handle described in the second article of this series is not feasible here because the looseness of the tympanic membrane renders the prosthesis unstable. A successful prosthesis must have an inherent stability. The cross-bar prosthesis described by Hayden was tried without success, as cicatrization slowly pulled it out of position. Many attempts at development of a stable prosthesis have resulted in a polyethylene-steel composite, much resembling a cross of Lorraine in configuration. The stem is No. 34 steel wire, with a loop at one end resting on the footplate. The stem slides freely through a short piece of PE 190 pierced transversely, which acts as a stabilizer. This piece of polyethylene sits snugly between the intratympanic course of the facial nerve and the promontory, in the oval window niche. The outer end of the stem is capped with a shorter piece of PE 60, which prevents its piercing the tympanic membrane or graft. A free graft is never used for this purpose, as it tolerates point-

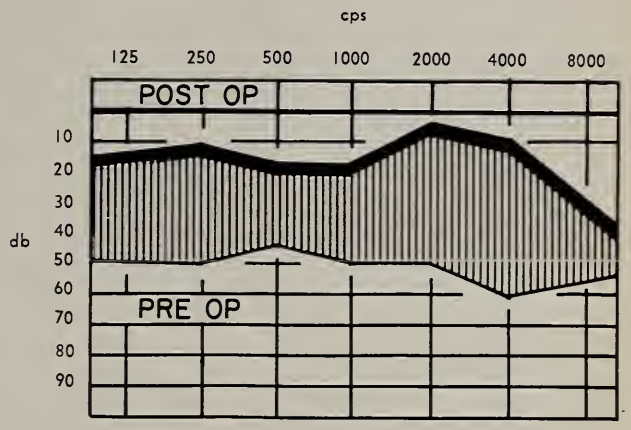


Fig. 9. Typical audiometric result showing the gain in hearing (shaded area).

pressure poorly. A perforation existing in this area is closed by sliding the tympanomeatal flap forward. Six cases which would have been type IV tympanoplasties by prior standards were converted to type III tympanoplasties by this method with uniformly satisfactory results.

Summary

After an initial fall in incidence occasioned by the advent of antibiotics, mastoidectomy is now increasing in incidence. This rise is by virtue of the increase in chronic mastoiditis. Most mastoidectomies today involve also some attempt at preserving or restoring the hearing mechanism. The discipline concerned with the organization of audiosurgical restorative techniques is termed tympanoplasty. Various types of tympanoplasties are feasible depending upon what is left after the excisive portion of the operation. Of these, type IV is the least successful. A higher degree of hearing is attainable with the use of a composite polyethelene-steel prosthesis and total restoration of the middle ear.

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Findings, Recommendations and Orders of the Insurance Commissioner, State of Michigan

On January 10, 1961, the Michigan Medical Service (Blue Shield) and the Michigan Hospital Service (Blue Cross) submitted to the Michigan Department of Insurance filings for which approval was requested.

The Blue Shield filing included:

1. A rate increase of 13.5 per cent projected for a two-year period, effective April 1, 1961.
2. The following certificate changes:
 (a) Substitution of days for months in respect to benefit waiting periods, benefit renewal periods, etc. (9 months would become 270 days; 3 months would become 90 days);
 (b) Reduction of the renewal period for tuberculosis, nervous and mental conditions, from 6 months to 90 days in all certificates;
 (c) A guarantee of a minimum of 30 days of in-hospital medical care for the treatment of an accidental injury when a member has less than 30 days of such care available at the time of such injury;
 (d) To allow obstetric and medical benefits for individual subscribers, as well as the two-person and family certificates with respect to group conversion contracts only.

The Blue Cross filing included:

1. A rate increase of 22.04 per cent projected for a two-year period, effective April 1, 1961.
2. The following certificate changes:
 (a) The 30 days hospital benefit period for the treatment of tuberculosis, nervous or mental conditions is to be incorporated into the present maximum benefit period of the certificates. As a result, the renewal proviso will be shortened from a 6-month waiting period without hospitalization for any condition to a 90 day period.
 (b) The maximum benefit period (120 days in the Comprehensive and the $50.00 Deductible Certificates; 30 days in the Economy and Non-Group Certificates) will be extended so as to provide at least 30 days of hospital care for the member admitted for initial treatment of traumatic bodily injuries immediately following an accident causing such injuries. For example, a Comprehensive member having exhausted 110 of the 120 days in a benefit period will be entitled to 20 days beyond the benefit period or a total of 140 days in that benefit period.
 (c) An additional new benefit will provide hospital care, on both an in-patient and out-patient basis, for dental treatment, if the service is for oral surgery, extraction of impacted teeth, multiple extractions under general anaesthesia or treatment necessary to safeguard the life or health of the member from the effect of dentistry because of a non-dental organic condition.
 (d) Group Conversion (Direct Payment) benefits will be modified to correspond with those furnished under the group certificates.
 (1) Full maternity benefits instead of a $14.00 per day room allowance.
 (2) Maternity benefits allowed on single contracts.
 (3) 120 days allowed instead of 30 days.
 (e) Maternity benefits will be provided on all certificates after 270 days of membership instead of after 9 months of membership under contracts that include maternity care as a benefit.
 (f) All time intervals related to benefit provisions are to be expressed in days instead of in months.
 (g) When a member is hospitalized in a non-participating hospital, the Service Association will provide $15.00 per day as an allowance rather than the present $14.00. The room allowance under the Economy and the $14.00 Daily Room Benefit Non-Group Care Certificates will be raised to $15.00.
 (h) The deductible payment to the hospital under the $50.00 Deductible Certificates will not be required for children. Such members will receive full contract services without the deductible charge until the end of the calendar year in which the age of 19 years is attained.
 (i) Several non-substantive changes in contract language are made.

Public hearings were held on these filings on February 7, 1961, in Detroit; February 15, 1961, in Grand Rapids; and February 16, 1961, in Lansing. Prior to the formal submission of these filings, examiners and other personnel of the Department of Insurance began a special study and review of the financial status, organizational structure, practices and procedures of both Michigan Medical Service and Michigan Hospital Service. In addition, consultations were held with Professor Walter J. McNerney and his staff at the University of Michigan, who have been engaged in a special study for the Governor's Commission on Pre-Paid Hospital and Medical Care Plans. Various members of the Department of Insurance also analyzed the great volume of mail directed to the Department and conferred with individual citizens (both professional and laymen) who indicated their desire to express personally their views with respect to any aspect of the filings submitted. Every conceivable effort was made to ascertain the pertinent facts on which a decision should be based.

General Discussion

Sitting through the public hearings on these applications for a rate increase has made me most mindful of the impact our decision will have on nearly 3½ million citizens of Michigan and the Blue Cross-Blue Shield programs. The importance of our decision is heightened by the sober reflection that the responsibility of this decision is, by law, vested in one man alone, the Commissioner of Insurance. The effect of his decision on the public's pocketbook can be just as

great as the enactment of a major tax measure by the Legislature. It is for this reason that I have carefully weighed every conceivable factor having a bearing on the question presented to me. In all the din that developed since the initial announcement that Blue Cross-Blue Shield would seek approval of a rate increase, I have recognized that my paramount responsibility was to arrive at a decision that would reflect the public interest, rather than the interest of any specific group who happen to have an identification with either program. Our orders and recommendations have been based on what the facts have disclosed to be necessary. There are no miracle ingredients or nostrums that would provide a basis for a determination acceptable to all concerned and at the same time resolve the problems confronting both organizations.

Our study of these two voluntary prepaid hospital and medical care plans indicates that they have, in the main, met popular expectations with respect to the purpose for which they were established. The good things they have accomplished over the years are conspicuous. Given their shortcomings, their importance to the health and well-being of our citizenry is beyond dispute. Our study also revealed that there is no persuasive evidence that any substantial savings can be accomplished in reducing the administrative costs of either plan. Such costs appear to be reasonable in relation to the size of the total operation.

Because of the recent history of rate increases, however, there is widespread consumer objection to the price that both plans charge for their services. This objection threatens the continued existence of both plans.

How to meet the objection of price is a hard question, but an urgent one. Our examination discloses that the financial status of Blue Shield is precarious, and it is only a question of time before the well runs dry. It is clear that our choice of alternatives for the solution of the financial problem is limited, increase rates or drastically reduce subscriber benefits. The financial picture for Blue Cross is only slightly less critical.

The public question as to why this should be cannot be answered by an explanation of spiraling medical costs, increased utilization and possible misuse alone. Indeed, both plans seem to have engaged in a calculated program of liberalizing benefits when it was apparent that they were headed for financial difficulty. The claim that the public wanted or demanded extension of coverage ignores the fact that private interests can be advanced under the cloak of giving the public what it supposedly wants. There have been, and still are, protagonists of both plans who fail to recognize that there are practical limitations to what people can afford to purchase, or that they are willing to buy.

Beyond the financial question, both plans are experiencing other perplexities and troubles. It is obvious that the maintenance of membership is a serious problem which must be faced by both organizations. Blue Shield has to cope with subscriber dissatisfaction occasioned by fees charged by non-participating doctors beyond those fixed in the Blue Shield schedule. There is also dissatisfaction among participating doctors as to Blue Shield's fee schedule. Some charge this schedule is weighted in favor of certain specialists to the disadvantage of general practitioners, internists, etc. This situation could well lead to an increase in the number of non-participating doctors who have no ceiling on the fee they can charge in addition to what they collect from Blue Shield.

Blue Cross is faced with comparative problems with respect to their hospital payment formula to participating hospitals. That this formula is vulnerable to criticism needs no further emphasis than that supplied by Blue Cross in their publication "The Status and Operation of Michigan Hospital Service," dated January, 1961. On page 71 of that report it is noted that critics of the formula charge: "The payment formula includes no positive incentive toward efficiency in operation, nor does it include a positive penalty for inefficiency in operation, or unwarranted increases in hospital operating cost." Non-participating hospitals, ineligible to become participating hospitals, are also most critical over the payment allowance which they receive. We found many subscribers were unaware that they are not eligible for full benefits under their Blue Cross contracts unless they are confined in participating hospitals.

Internally, both corporations have established control measures to police abuse and misuse of their respective services. Such control measures are good to the extent they are utilized. However, more successful efforts are dependent upon the cooperation of the public, the doctors and hospital administrators. While we are unable to document the extent of abuse and misuse, we are of the opinion that there is a tendency by many professional people to minimize the prevalence of such practices. The vast number of complaints on this score are not susceptible to evaluation by our staff. However, numerous communications and conversations leave no doubt that a great number of our citizens have become cynical about the propriety and equity of some medical and hospital charges.

Quite conceivably, the source of much of the public's misunderstanding and complaint stems from the schedule of payments to doctors in non-surgical confinement cases. They receive, depending on the subscriber's contract, as high as $15.00 for the first day of confinement in the hospital; $6.00 per day from the second to the twentieth day; and $4.80 per day from the twenty-first to the one-hundred and

twentieth day. These fees are automatic and do not depend on the doctor providing any further service, other than being the admitting physician.

Our review and study establishes the impression that administrative personnel in both organizations are more responsive to the views and opinions of doctors and hospital administrators than those of the public. On more than one occasion we have noted examples of administrative timidity when confronted with opposition of segments of the medical profession over administrative decisions. This timidity becomes particularly obvious when propositions are advanced to secure amendments to their enabling acts. They have spent too much time convincing themselves that such action would not be in the best interests of their programs. Certainly, a review of the franchise under which they are operating with doubt and discomfort would be in order and in the public interest.

At the present time, Blue Cross handles the auditing of some member hospitals in a cursory fashion. Thorough audits are of vast importance in determining benefit payments to the hospitals. It would appear that Blue Cross is loathe to throw its weight around to require sound accounting procedures such as set forth by the American Hospital Association.

In this general discussion, we have attempted to highlight the more important findings of our various efforts. More specific detail will be found in the Survey and Review written by staff personnel. I fully expect that more complete findings will also be supplied by Professor McNerney's inquiry and that these will be even more thoroughly documented than time permitted us to undertake.

Our discussion is not for the purpose of finding fault, but rather to point up the fact that both of these corporations are looked upon by more and more people as quasi public utilities. It is obvious that this must be recognized and both organizations charged with a greater degree of public accountability. This becomes tremendously important if prepaid voluntary health programs are to survive the challenges that confront them. Challenges such as the greater percentage of elder citizens, unemployment of so many of our workers and the financial impact that the cost of these programs have on employers, who in many instances pay all or part of the cost of the coverage.

The Michigan Blue Shield and Blue Cross programs rank among the best in the United States in terms of benefits provided and administrative costs of the plans. The service they have rendered has been invaluable in providing the citizens of Michigan necessary health care. The following recommendations and orders are presented to assist management in continuing to provide such service and at the same time meet their financial requirements.

Recommendations

The distinctive feature between the Blue Shield-Blue Cross programs from other forms of health insurance is their intimate relationship with the medical profession and the health services industry.

We urge that the various professional organizations representing such groups extend more extensive assistance in resolving the pressing problems that have occasioned public criticism of Blue Shield-Blue Cross.

It is in the public interest that as many doctors as possible participate in their own plan.

We recommend that the Michigan State Medical Society and its constituent groups initiate such action as necessary to accomplish this end.

We have noted with interest that a great number of committees have been established within the Blue Shield-Blue Cross organizations.

It is recommended that the scope of such committees' assignments and the extent of their activities be reviewed to determine whether they are meeting their original purpose in the most efficient and effective fashion.

Our mail and public hearings indicated considerable public interest that deductible provisions be included in both Blue Shield and Blue Cross contracts. Without commenting on the merits of existing deductible provisions already provided for and contemplated, it is obvious that the public is not aware of their availability.

It is recommended that steps be taken to acquaint subscribers of such deductible provisions so they may exercise freedom of choice.

Ambiguous language in both Blue Shield and Blue Cross contracts causes considerable confusion in the minds of subscribers as to the benefits to which they are entitled. This has also opened the door to administrative interpretations of contract benefits which has been a source of irritation to some claimants.

It is recommended that thought be given to ways and means of modernizing such contract language to assist the public in understanding what they are purchasing.

The following recommendations are advanced for the consideration of the Michigan State Legislature:

1. *Public Acts 108 and 109, Public Acts of 1939, be amended to require that a majority of the members of the governing bodies of both corporations be public members.*

2. *Public Act 108 be amended so as to make it possible for doctors of osteopathy to become participating doctors.*

3. *Public Act 108 and Public Act 109 be amended so as to require the filing of lists of participating doctors and participating hospitals with each county clerk. Such lists to be limited to participating doctors*

and participating hospitals within each county. Similar lists should also be required to be kept on file in each branch office of Blue Shield and Blue Cross located in Michigan. These lists to be open and available for public inspection.

4. *That consideration be given to the feasibility of placing the authority in some state agency for the approval of hospital rates.*

5. *That provision be made within the budget of the Department of Insurance for two auditors to be permanently assigned to Blue Shield and Blue Cross.*

Orders

With respect to the Blue Shield filing:

1. *Michigan Medical Service is hereby granted a rate increase in the amount of 10 per cent, effective June 1, 1961, and conditioned upon the Michigan Medical Service having, prior thereto, submitted to the Commissioner of Insurance of the State of Michigan a plan acceptable to the Commissioner whereby the contingency reserve, over and above all liabilities, shall be maintained. This reserve shall consist of monthly accumulations equal to 3 per cent of each month's premium income, until such time as the reserve equals three months' premium income. No plan will be approved which contemplates an increase in subscribers' rates beyond that granted herein or a reduction in subscriber benefits heretofore and herein authorized by the Commissioner of Insurance.*

2. *The following certificate changes are approved:*

(a) Substitution of days for months in respect to benefit periods.

(b) Modification of group conversion benefits to correspond with those furnished under the group certificate: (1) Maternity benefit allowance on single contracts.

3. *All other certificate changes for which approval was requested are hereby disapproved.*

This action is taken because of the failure of Michigan Medical Service to exhibit an adequate basis to substantiate their projected costs. Those extensions of benefits denied herein may be resubmitted if limited to those subscribers who are willing to pay an additional premium, such premium to be both reasonable and adequate for the benefits provided.

With respect to the Blue Cross filing:

1. *Michigan Hospital Service is hereby granted a rate increase in the amount of 20 per cent, effective June 1, 1961. Michigan Hospital Service is directed to set aside 3 per cent of earned premium income until the assigned reserve equals three months' premium income.*

Our approval of a 20 per cent rate increase for Michigan Hospital Service reflects a 2.04 per cent reduction from their original request. The reduction in income that this cut will occasion will be minimized by our denial of certain extensions of benefits requested in Blue Cross' application of January 10, 1961.

It is also anticipated that increased emphasis on unnecessary utilization and stricter accounting requirements for participating hospitals should also result in further savings.

2. *The following certificate changes are approved:*

(a) Modification of group conversion benefits to correspond with those furnished under the group certificates. (1) Full maternity benefits instead of a $14.00 per day room allowance. (2) Maternity benefits allowed on single contracts. (3) 120 days allowed instead of 30 days.

(b) Maternity benefits to be provided on all certificates after 270 days of membership instead of after 9 months of membership under contracts that include maternity care as a benefit.

(c) All time intervals related to benefit provisions to be expressed in days instead of in months.

(d) Increase in allowance for non-participating hospitals from $14.00 per day to $15.00.

(e) Deductible provisions not to apply to children under the age of 19 years in the $50.00 deductible certificate.

(f) Certain non-substantive changes in contract language.

3. *All other requested changes are hereby disapproved.*

We have approved certain extension of benefits under the Blue Cross coverage because of their social desirability. The costs of such changes have been adequately documented and costs have been included in the requested rate increase. Specifically, these will correct certain inequities with respect to those individuals who find it necessary to switch from group plans to direct payment contracts. A large number of these people are unemployed workers and retirees. Relief has also been granted to non-participating hospitals in that equity would seem to call for such action. Those extensions of benefits denied herein may be resubmitted if limited to those subscribers who are willing to pay an additional premium, such premium to be both reasonable and adequate for the benefit provided.

Conclusion

Undoubtedly, our action in approving an increase in the cost of Blue Shield-Blue Cross coverage will be critically received by many of our citizens. The decision was not an easy one and it was made more difficult by a realization of its impact on elder citizens with limited incomes and the unemployed.

If there had been some alternative solution we would have advanced it. In the absence of any substitute program to meet the health needs of the 3½ million Blue Shield-Blue Cross subscribers, we are compelled to recognize our responsibility to maintain the solvency of both corporations so that they might meet their contractual obligations to their subscribers.

The necessary increase in rates is not unique to Michigan. In the past year such states as Maryland, New York, New Jersey, Ohio and Pennsylvania have found it necessary to grant increases; in most instances even larger than those we have granted.

We recognize that this is small consolation to those who must dig deeper to pay the increase and those who must contemplate dropping their coverage because of inability to afford it. Still, we would not be justified in depriving those who are willing and able to pay for such coverage the chance to procure it. An arbitrary or capricious denial of the requests would inevitably have had these consequences.

The public discussion of this question has had a healthy effect. It should cause all of us who are identified with the programs, no matter our role, to search for ways and means to improve both programs. We must do this, as well as stabilize the cost of such coverage, if these plans are not to be replaced with some other type of health care plan. The American people have always turned to other remedies when existing institutions failed or were not able to meet their responsibilities.

FRANK BLACKFORD, *Insurance Commissioner*
April 6, 1961.

Boston University Appoints Dean

Lamar Soutter, M.D., professor of surgery and acting dean since September, has been appointed dean of the Boston University School of Medicine. He has been associated with the University since 1952.

Drug Firms Aid Project HOPE

Fifty-two prescription drug manufacturers contributed in excess of $780,000 in products and cash to Project HOPE, according to Dr. William B. Walsh, president of the People-to-People Health Foundations, sponsor of the Project. Over $100,000 of the companies' contributions were in cash. Product values were computed according to manufacturers' wholesale prices.

"The support of the member companies of PMA has earned the unending gratitude of the people of Indonesia and Vietnam," Dr. Walsh said, "and it serves as an example of enlightened generosity to our own fellow citizens. This response has earned the deepest gratitude of all of us connected with Project HOPE."

HOTEL RESERVATIONS
MICHIGAN STATE MEDICAL SOCIETY

96th Annual Session

Grand Rapids, September 27-28-29, 1961

The reservation blank below is for your convenience in making your hotel reservations in Grand Rapids. Please send your application to the Committee on Hotels for MSMS Convention, Pantlind Hotel, Grand Rapids, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Committee on Hotels by sharing a room with another registrant, when convenient.

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Committee on Hotels,
Michigan State Medical Society
c/o Jack Ament, Room Reservation Manager
Pantlind Hotel, Grand Rapids, Michigan

Please make hotel reservation(s) as indicated below:

———— Single Room(s) ————persons

———— Double Room(s) for ————persons

———— Twin-Bedded Room(s) for ————persons

Arriving September ———hour———A.M.———P.M.

Leaving ————————hour———A.M.———P.M.

Hotel of First Choice: ————————————

Second Choice: ————————————

Names and Addresses of all applicants including persons making reservations:

Name	*Address*	*City*	*State*

Date ———— Signature ————————

Address ———————— City ————

• **THE HOLDER OF A HOTEL RESERVATION** who fails to show up . . . and fails to cancel his reservation . . . causes gastric hyper-peristalsis, hypersecretion of the hydrochloric acid, and rubus of the gastric mucosa to the hotel manager.

When convention reservations fill a hotel to the capacity, a room not occupied is a loss in $$$ that cannot be reclaimed.

The MSMS Annual Session always means a capacity house in the Grand Rapids headquarters hotel.

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Why Contact Lenses?

Why should the medical practitioner know about contact lenses? Why should the medical practitioner be concerned with ophthalmology's problems with contact lenses?

Why! Your patients are being fitted and are wearing them. If you are concerned with their physical health, then you must be concerned with the health of their most delicate sensory organ—the eye.

If your patients ask your professional advice about the advisability of wearing contact lenses, what is your answer? Your answer should be based on this additional information. *Why* does the individual want contact lenses? *Who* will do the fitting? *How* regularly and skillfully will the follow-up evaluation be done?

The "*Why*" should have a medical background and not be a whim precipitated by glamour advertising. Contact lenses improve vision and visual fields in large or irregular refractive errors, particularly the hyperopia of the post-cataract extraction patients. Contact lenses give vision to many patients whose occupations make wearing spectacles difficult or impractical. There is a group of patients with corneal disease or injury that can be helped with corneal contact or scleral molded lenses today. The success and practicality of these improvements in ophthalmology are presented for your general knowledge and information.

The "*Why*" dealing with purely cosmetic reasons as "My girl friend has them," or "My boy friend thinks I look terrible in glasses," may lead to wasted time, money and unhappiness without complete understanding. It is here that your responsibility as the family physician and our responsibility as the ophthalmologist is the making of an accurate, thoughtful decision. Plastic surgery has proved the psychological advantages of improved appearance; and now when vision is limited or restricted, contact lenses can give the same psychological advantages. But only that intangible sixth sense developed by years of medical training and experience will enable the physician to give the needed advice.

The "*Who*" is extremely important. Contact lenses are prosthetic devices and thus require medical observation and evaluation by an ophthalmologist before, during, and after fitting. The health of the eye must be checked by refraction, funduscopy, biomicroscopy, tonometry, perimetry, and motility testing before contact lens consideration. Then after the lenses are worn, this testing is equally important for protection of the eye.

Then the "*How*" follows. Will the patient's eyes be checked

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regularly even after apparent successful wearing has been accomplished? The early corneal trauma, degenerations and vascular changes can be diagnosed before permanent change only by careful three to four-month regular examinations. How regularly and skillfully a patient will be evaluated is of prime concern in sound advice to the prospective contact lens wearer.

Ophthalmology is working, studying and learning belatedly about this relatively new field in a scientific analytical fashion. Part of this study must be the education of the entire medical profession in a general understanding of contact lenses, their limitations, indications, and dangers.

—Robert J. Crossen, M.D.

Insurance Commissioner's Report

In this issue of The Journal, we are publishing in full the Insurance Commissioner's Report, findings and orders following the request of Blue Cross and Blue Shield for rate increases. Blue Shield, Michigan Medical Service, will accept under protest, and attempt to live with the restrictions. Blue Shield is thankful for the many complimentary remarks. Successful operation will require meticulous cooperation by both patients and doctors who render service as well as diligent administration. The State of Michigan cannot afford to lose this service.

Not Licked Yet

The American Medical Association Annual Conference held in New York City, June 25-30, 1961, was probably one of the most important ever held, not only for its scientific excellence, but from the standpoint of medical economics, the problems the profession must face, threats to its independent existence, and the future. Every member of the House of Delegates was in attendance (either the delegate or his alternate) probably for the first time in history. The councils, boards, committees, the executive officials, all had their reports prepared, most of them in a pre-convention volume. The Board of Trustees had an unusual number of supplemental reports. There were more than 115 resolutions presented from various sources, state medical societies, delegates, sections, et cetera—an unprecedented number. Most of these were in support of certain federal legislation, administrative problems, ethical and professional ideas including some economic questions. Some were in active opposition to King-Anderson type legislation.

Many of these reference committees had fifteen or twenty resolutions to study, and worked all night, hearing anyone who wished to testify and then working out the mimeographed reports. The most important had to do with legislation and public relations. This topic was also considered by the Conference of Presidents and Other Officers of State Medical Societies.

Conference of Presidents

The Conference was established originally by Dr. Andrew S. Brunk, former President of the Michigan State Medical Society, who called a special meeting of seventeen presidents to consider unsolved problems at the time, outside the purview of the American Medical Association. They were largely problems of procedure and methods growing out of the newly developed medical care for our people, and how to pay for it. Medical pioneers in Michigan, California, and in some other areas, evolved a method of prepayment for medical and hospital care. In operation, the plan was a success. Problems developed, but the people were being cared for. The first Conference of Presidents took up those questions and many others which came up during the years. This year, 1961, the prime question was federal legislation. Two congressmen were on the schedule and talked to the largest group ever assembled for this conference, which was completely and enthusiastically supported by the officials of the American Medical Association. Congressman Bourwald E. Hall, M.D., of Missouri, and Walter H. Judd, M.D., of Minnesota, cautioned about the political activities, bureaucratic encroachment and progressive extension of government control of the practice of medicine. Apparent bureaucratic disaffection with the Kerr-Mills Bill, which is now giving service to the aging, was cited. Bureaucratic approach, support and efforts to enact the King-Anderson type of legislation, would put medical care under social security and its special tax. The socializers are misinforming people, by obviously not including medical attention which has been promised. That type of legislation (King-Anderson) is totally insufficient.

House of Delegates

This introduction to the doctors, state and local officers, delegates and alternates, set a sober atmosphere for the House of Delegates. Numerous resolutions bearing on this same general topic gave the reference committee on legislation and public relations

a tremendous amount of work to do. They held many hours of hearings at which everyone was urged to testify and no one was denied. Then they spent most of two nights writing their report. We shall quote and comment upon one small section of that report which was adopted unanimously:

"Your reference committee strongly recommends that the House of Delegates of the American Medical Association records its opposition to any legislation of the King-Anderson type. Its opposition is based on the facts that such legislation does not meet the needs of the situation; interferes with the doctor-patient relationship; interferes with the rights of doctors employed in hospitals; is inordinately expensive; leads inevitably to further encroachments by government into medical care; results eventually in a deterioration of the type of medical care rendered the public; and is therefore detrimental to the public interest.

"The House of Delegates invites attention to the fact that the medical profession is the only group which can render medical care under any system and that the medical profession is best qualified to determine how the best medical care can be delivered.

"The House of Delegates believes that the medical profession will see to it that every person receives the best available medical care regardless of his ability to pay, and it further believes that the profession will render that care according to the system it believes is in the public interest and that it will not be a willing party in implementing any system which we believe to be detrimental to the public welfare."

Most of this resolution was introduced on the floor by Louis H. Bauer, M.D., Past President of the American Medical Association, after a speech in which he invited attention to the fact that never had the medical profession been faced with such vital implications and threats as now—not even in the Wagner-Murray-Dingell Bills of twenty years ago.

What of the Future?

When he introduced the resolution just quoted, Dr. Bauer described the bureaucratic take-over of medicine and the refusal to use the Kerr-Mills Bill which is now caring for, or could if allowed, the aging in most of the states. The bureaucratic socializers claim that 12 million people are without care and must have it—therefore the King-Anderson Bill must be passed.

Where will the medical profession be? Physicians are specifically not included in this administration program. Very specifically, hospital care is provided after the patient pays the first $90; diagnostic care is included after the patient pays the next $20. Under the law, the only way to get any medical care is for the patient to pay for it, or have it come through physicians employed by the hospital. This is what the medical profession must face.

We are reminded of what happened in England. The government proposed to the British Medical Association that it buy the practices of the doctors and have the doctors work for the government on a quota basis. Only 17 per cent of the members of the British Medical Association voted yes, so the doctors thought they were safe. The Government went to these 17 per cent and offered to buy their practices; it also bought any other practices which were for sale. The Government wound up with about 40 per cent and started its program. The doctors were in it without their consent and in spite of their negative vote. We hope that is not attempted here.

Public Relations

There was a tense feeling in New York. The medical profession is on trial; it must take care of senior citizens over sixty-five in some way. We have the answer. The Kerr-Mills Bill will do it except in a few limited areas, but our doctors must see that these people do not suffer. The doctors must make certain that the public in general gets a little more favorable concept of the profession than now seems to be developing. The individual doctor seems to be well liked by his patients but they feel the whole profession is worthy of condemnation. If we wish to retain and continue in private practice, all of our doctors must make every effort to make a favorable impression on the public in general. In Michigan, we have just gone through another course of searching inquiry and criticism, hunting for things to complain about, incident to a re-adjustment of Blue Shield rates. That is now accomplished.

The Michigan Insurance Commissioner complained that many doctors overcharged, accepting the Blue Shields rates as part payment only, and made other charges. Michigan Blue Shield was set up originally and continues to be a service program to give complete care for those under income limit. During the years, it has been suggested that doctors, when caring for their Blue Shield patients, discuss with them extra charges if they are over income limit, or if extra charges are contemplated. With such understanding, there can be no justification for much of the generalized criticism which was again made about the profession during the hearings before the Insurance Commissioner.

The feeling in New York at the AMA Conference was serious, that if medical men value their independence, they must follow strictly the principles of ethics long ago established and adopted by all doctors. If good ethics and good will procedures are followed and we still are compulsorily taken over by government, the profession must remember what happened in England. We have been warned.

Acknowledgment

We wish to express our sincere thanks to Dr. Robert J. Crossen of Detroit for his excellent assistance in the preparation of papers for the August number of THE JOURNAL which is devoted to Ophthalmology.

OUTLINE OF 1961 ASSEMBLY AND SECTION SPEAKERS—96TH ANNUAL SESSION MSMS

Grand Rapids, September 27-28-29, 1961

ASSEMBLY TALKS

Wednesday September 27, 1961

9:00-9:30 a.m.
Medicine
ALEXANDER B. GUTMAN, M.D.
New York, New York

9:30-10:00 a.m.
Medicine
JOSEPH V. MESSER, M.D.
Boston, Mass.

10:00-11:00 a.m.
INTERMISSION TO VIEW EXHIBITS

11:00-11:30 a.m.
Medicine
JOHN H. MOHER, M.D.
Philadelphia, Pa.

11:30-12:00 noon
Public Health and Preventive Medicine
JEREMIAH STAMLER, M.D.
Chicago, Ill.

12:00-12:30 p.m.
Obstetrics-Gynecology
ROBERT B. GREENBLATT, M.D.
Augusta, Ga.

12:30-2:00 p.m.
Luncheon (See Section Meetings)

2:00-3:00 p.m.
Dermatology-Syphilology
MARCUS R. CARO, M.D.
Chicago, Ill.
and
JOHN R. HASERICK, M.D.
Cleveland, Ohio

3:00-4:00 p.m.
INTERMISSION TO VIEW EXHIBITS

4:00-4:30 p.m.
Obstetrics-Gynecology
MITCHELL J. NECHTOW, M.D.
Chicago, Ill.

4:30-5:00 p.m.
Obstetrics-Gynecology
SAUL B. GUSBERG, M.D.
New York, New York

5:00-5:30 p.m.
Urology
CLARENCE V. HODGES, M.D.
Portland, Oregon

Thursday September 28, 1961

9:00-9:30 a.m.
Surgery
LAWRENCE G. HAMPSON, M.D.
Quebec, Canada

9:30-10:00 a.m.
Surgery
CUSHMAN D. HAAGENSEN, M.D.
New York, New York

10:00-11:00 a.m.
INTERMISSION TO VIEW EXHIBITS

11:00-11:30 a.m.
Surgery
ANGUS D. MCLACHLIN, M.D.
Ontario, Canada

11:30-12:00 noon
Surgery
WM. ALTEMEIER, M.D.
Cincinnati, Ohio

12:00-12:30 p.m.
Anesthesiology
WM. S. DERRICK, M.D.
Houston, Texas

12:30-2:00. p.m.
Luncheon (See Section Meetings)

2:00-2:30 p.m.
Ophthalmology
BRADLEY R. STRAATSMA, M.D.
Los Angeles, Calif.

2:30-3:00 p.m.
Otolaryngology
FRANK D. LATHROP, M.D.
Boston, Mass.

3:00-4:00 p.m.
INTERMISSION TO VIEW EXHIBITS

4:00-4:30 p.m.
Radiology
GWILYM S. LODWICK, M.D.
Columbus, Mo.

4:30-5:00 p.m.
Gastroenterology-Proctology
HYRUM R. REICHMAN, M.D.
Salt Lake City, Utah

5:00-5:30 p.m.
Occupational Medicine
LEMUEL C. MCGEE, M.D.
Wilmington, Del.

Friday September 29, 1961

9:00-11:30 a.m.
Nervous and Mental Diseases and General Practice
WINSLOW G. FOX, M.D.
Ann Arbor, Mich.
IVAN C. BERLIEN, M.D.
Miami, Fla.
THEODORE A. WATTERS, M.D.
New Orleans, La.

10:00-11:00 a.m.
INTERMISSION TO VIEW EXHIBITS

11:00-11:30 a.m.
(continuation of above panel)

11:30-12:30 p.m.
Pediatrics
JAMES L. WILSON, M.D.
Ann Arbor, Mich.
J. ROSWELL GALLAGHER, M.D.
Boston, Mass.
CARL P. HUBER, M.D.
Indianapolis, Ind.

12:30-1:00 p.m.
FINAL INTERMISSION TO VIEW EXHIBITS

(See Section Meetings)

MEETINGS OF MSMS SECTIONS

Wednesday September 27, 1961

12:00 noon luncheon-meeting
Section on Dermatology-Syphilology
E. RICHARD HARRELL, M.D.
Ann Arbor, Mich.
MARCUS R. CARO, M.D.
Chicago, Ill.
JOHN R. HASERICK, M.D.
Cleveland, Ohio

5:30 p.m. meeting
Section on General Practice
MITCHELL J. NECHTOW, M.D.
Chicago, Ill.

12:30 p.m. luncheon-meeting
Section on Gynecology-Obstetrics
NORMAN F. MILLER, M.D.
Ann Arbor, Mich.
MITCHELL J. NECHTOW, M.D.
Chicago, Ill.
ROBERT B. GREENBLATT, M.D.
Augusta, Ga.
SAUL B. GUSBERG, M.D.
New York, N. Y.

5:30 p.m. meeting-reception
Section on Internal Medicine
RICHARD J. BING, M.D.
Detroit, Mich.

12:00 noon luncheon-meeting
Section on Public Health and Preventive Medicine
JEREMIAH STAMLER, M.D.
Chicago, Ill.

5:30 p.m. meeting-reception-dinner
Section on Surgery
LESTER P. DODD, LL.B.
Detroit, Mich.

5:30 p.m. meeting
Section on Urology
CLARENCE V. HODGES, M.D.
Portland, Ore.

Thursday September 28, 1961

5:30 p.m. reception-dinner-meeting
Section on Anesthesiology and Michigan Society of Anesthesiologists
WM. S. DERRICK, M.D.
Houston, Texas

6:00 p.m. reception-dinner-meeting
Section on Gastroenterology-Proctology
HYRUM R. REICHMAN, M.D.
Salt Lake City, Utah

5:30 p.m. reception-dinner-meeting
Section on Nervous and Mental Diseases and Michigan District Branch of American Psychiatric Association and Michigan Society of Neurology and Psychiatry
IVAN C. BERLIEN, M.D.
Miami, Fla.

5:30 p.m. meeting-reception
Section on Occupational Medicine
LEMUEL C. MCGEE, M.D.
Wilmington, Del.

5:30 p.m. meeting
Section on Ophthalmology
BRADLEY R. STRAATSMA, M.D.
Los Angeles, Calif.

5:30 p.m. meeting-reception-dinner
Section on Otolaryngology
FRANK D. LATHROP, M.D.
Boston, Mass.

5:30 p.m. meeting
Section on Radiology
GWILYM S. LODWICK, M.D.
Columbus, Mo.

Friday September 29, 1961

2:00-5:00 p.m. meeting
Sections on Pathology and Radiology and Michigan Pathological Society
ERNEST E. AEGERTER, M.D.
Philadelphia, Pa.
and
GWILYM S. LODWICK, M.D.
Columbus, Mo.

6:00 p.m. reception-dinner-meeting
Section on Pediatrics and Michigan Branch, American Academy of Pediatrics
J. ROSWELL GALLAGHER, M.D.
Boston, Mass.

Michigan State Medical Society

The Ninety-Sixth Annual Session

Pantlind Hotel-Civic Auditorium, Grand Rapids
September 27-29, 1961

Meetings of Special Societies and Sections

WEDNESDAY, SEPTEMBER 27

The MSMS Section on Dermatology and Syphilology will meet at 12:00 noon for luncheon in the Schubert Room of the Pantlind Hotel, Grand Rapids. There will be a panel presentation on "Serendipity Conference" moderated by E. Richard Harrell, M.D., of Ann Arbor. The panelists are Marcus R. Caro, M.D., Chicago, and John R. Haserick, M.D., Cleveland.

The MSMS Section on Obstetrics and Gynecology will meet for luncheon at 12:30 p.m. in the Continental Room of the Pantlind Hotel, Grand Rapids. The program will be a panel discussion on "Carcinoma of the Fundus" moderated by Norman F. Miller, M.D., Ann Arbor. The other participants are Robert B. Greenblatt, M.D., Augusta, Georgia; Saul B. Gusberg, M.D., New York City; and Mitchell J. Nechtow, M.D., of Chicago.

The MSMS Section on Public Health and Preventive Medicine will sponsor a 12:00 noon luncheon-meeting in the Sadler Lounge of the Pantlind Hotel, Grand Rapids. The speaker is Jeremiah Stamler, M.D., of Chicago, who will talk on "Development of a Heart Disease Control Program in a Local Board of Health."

The Michigan Chapter of the Committee on Trauma, American College of Surgeons, will meet at 12:30 p.m. for luncheon followed by an afternoon meeting and dinner.

Afternoon Session

P.M.

12:30 Luncheon at the Peninsular Club, Grand Rapids, followed by meeting in the Schubert Room of the Pantlind Hotel

2:00 to 3:00 "Mechanical Hyperventilation as a New Treatment of Crushing Injuries of the Chest"
E. Trier Moersch, M.D.
Discussers: Leo J. Kenney, M.D., Grand Rapids—"Experiences with the Moersch Respirator in Non-traumatic Cases"
Clare E. Basinger, M.D., Grand Rapids — "Experience with the Moersch Respirator in the Injured Patient"

3:00 *Intermission*

3:15 "Trimalleolar Fractures of the Ankle"—Harvey M. Andre, M.D., Grand Rapids

3:30 "The Amputee"—Alfred B. Swanson, M.D., Grand Rapids

3:45 "Burn Therapy"—Ralph Blocksma, M.D., Grand Rapids

The MSMS Section on Urology will meet at 5:30 p.m. in Room 124 of the Pantlind Hotel. Speaker is Clarence V. Hodges, M.D., Portland, Oregon, on "Repair of Ureteral Injuries."

The MSMS Section on Internal Medicine will meet at 5:30 p.m. followed by a reception in Room 222 of the Pantlind Hotel. Speaker is Richard J. Bing, M.D., Detroit, on "Coronary Heart Disease and the Regulation of the Coronary Circulation in Man."

The MSMS Section on General Practice will meet at 5:30 p.m. in Room 327 of the Pantlind Hotel. Speaker is Mitchell J. Nechtow, M.D., Chicago, who will talk on "Office Gynecology."

The MSMS Section on Surgery will meet at 5:30 p.m. for reception, dinner, and meeting, in the Sadler Lounge of the Pantlind Hotel. Lester P. Dodd, LL.B., Detroit, will talk on "Guaranteed Procedures for Inviting Malpractice Suits."

The Michigan Orthopaedic Society will meet at 5:30 p.m. for reception, dinner, and evening program at the Peninsular Club. Speaker will be Paul R. Lipscomb, M.D., Mayo Clinic. The title of his paper is "Unsolved Problems of Tendons and Their Environs." All interested physicians are invited; make reservations through George T. Aitken, M.D., 50 College Avenue, S.E., Grand Rapids.

The Michigan Society of Obstetricians and Gynecologists will meet at 5:30 p.m. for reception, dinner and evening program in the Continental Room of the Pantlind Hotel. The after dinner speaker will be Wm. N. Hubbard, M.D., Dean of the University of Michigan Medical School.

All members of the Michigan State Medical Society and their wives are cordially invited to attend this dinner and to hear Dean Hubbard's address. For reservations, write John E. Clifford, M.D., 2108 David Broderick Tower, Detroit 26, and enclose check for $6.00 per person or $12.00 per couple.

The Michigan Chapter of the American College of Chest Physicians will meet at 6:30 p.m. for a reception and dinner-meeting in Room 328 of the Pantlind Hotel.

THURSDAY, SEPTEMBER 28

The MSMS Section on Occupational Medicine will meet at 5:00 p.m. for a meeting and reception, Rooms 322 and 324 of the Pantlind Hotel. Speaker is Lemuel C. McGee, M.D., of Wilmington Delaware, who will talk on "Trends in Health Programs for Employees."

The MSMS Section on Radiology will meet at 5:30 p.m. in Room 222 of the Pantlind Hotel. Gwilym S. Lodwick, M.D., of Columbus, Missouri, will present "Computer Diagnosis in Radiology."

The MSMS Section on Ophthalmology will meet at 5:30 p.m. in Room 328 of the Pantlind Hotel. Bradley R. Straatsma, M.D., of Los Angeles, will present "Melanotic Epibulbar Tumors."

The MSMS Section on Otolaryngology will meet at 5:30 p.m. in Room 323 of the Pantlind Hotel. Speaker is Frank D. Lathrop, M.D., of Boston, on "Parotid Gland Tumors." This meeting will be followed by dinner at an outside club.

The MSMS Section on Gastroenterology and Proctology will meet at 6:00 p.m. for reception, dinner and evening program at the Peninsular Club. Speaker is Hyrum R. Reichman, M.D., Salt Lake City, who will talk on "Treatment of Diverticulitis."

The MSMS Section on Anesthesiology and the Michigan Society of Anesthesiologists will meet in the

Aloha Room of the Pantlind Hotel at 5:30 p.m. for reception, dinner, and evening program. Wm. S. Derrick, M.D., of Houston, Texas, will present "Anesthesiology and the Texas Medical Center in Houston."

The MSMS Section on Nervous and Mental Diseases and the Michigan District Branch of the American Psychiatric Association and the Michigan Society of Neurology and Psychiatry will meet at 5:30 p.m. for reception, dinner, and evening meeting, in the Schubert Room of the Pantlind Hotel. Ivan C. Berlien, M.D., of Miami, Florida, will present "Psychic Energy."

The Michigan Diabetes Association will meet at 6:00 p.m. for reception, dinner, and evening program, in the Apache Room of Win Schuler's Restaurant, Grand Rapids. Solomon A. Berson, M.D., Chief, Radioisotope Service, Veterans Administration Hospital, Bronx, New York, will talk on "Plasma Insulin Concentrations in Man."

The Michigan Chapter, Flying Physicians Association, will hold a luncheon-meeting at 12:15 p.m. in the Schubert Room of the Pantlind Hotel.

FRIDAY, SEPTEMBER 29

The Michigan Pathological Society will hold a business meeting at 10:00 a.m. in the Schubert Room of the Pantlind Hotel.

The MSMS Section on Pathology and the MSMS Section on Radiology, and the Michigan Pathological Society will meet from 2:00 to 5:00 p.m. in the Schubert Room of the Pantlind Hotel. The program will be a seminar on "Bone Tumors." Moderator is Ernest E. Aegerter, M.D., of Philadelphia, and panel participant will be Gwilym S. Lodwick, M.D., of Columbus, Missouri.

The MSMS Section on Pediatrics and the Michigan Branch of the American Academy of Pediatrics will meet at 6:00 p.m. for reception, dinner, and evening program in the Sadler Lounge of the Pantlind Hotel. Speaker is J. Roswell Gallagher, M.D., of Boston, who will talk on "The Adolescent and Our Society."

The Wayne State University College of Medicine Alumni Association will maintain a headquarters suite in the Pantlind Hotel during the MSMS Annual Session. All alumni, faculty, and friends of Wayne State University are cordially invited to visit their hospitality room.

The Annual Session of the Woman's Auxiliary to the Michigan State Medical Society will convene at the Pantlind Hotel, Grand Rapids, September 26-28. Registration will open on the Muzak Mezzanine at noon on Tuesday, September 26, at which time the Hospitality Room will also open in Parlor A.

Arrangements have been made for the furniture showrooms in the Exhibitors Building, just across the street from the Hotel, to be open on September 26 only from 10:00 a.m. to 12:00 noon and from 2:00 to 4:00 p.m. No tickets will be needed for admittance. Members of the Kent County Medical Auxiliary will serve as hostesses and will be in the building lobby to greet you and answer your questions. Visitors will be permitted to roam at will.

The Annual Meeting will commence at 9:30 a.m. on Wednesday, September 27, and at 9:00 a.m. on Thursday, September 28. The earlier-than-usual-opening hours reflect the decision to dispense with the Wednesday afternoon meeting; the Past Presidents' luncheon will be the final program of the day on Wednesday, September 27.

At the Wednesday luncheon, a fashion show will be presented by M. Morgan and with ten auxiliary members modeling.

It is hoped that each Auxiliary member will realize that she is urged to attend this annual program. Every effort is being made to offer an interesting and informative convention and an entertaining one as well.

MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

Occidental Hotel, Muskegon

TUESDAY, SEPTEMBER 26, 1961

P.M.
8:00 Hospitality Room—Courtesy of Muskegon County Medical Auxiliary—Mezzanine

WEDNESDAY, SEPTEMBER 27, 1961

Morning Session

A.M.
9:00 Registration—Chairman, Miss Jenice Lupien—Mezzanine
10:00 "Welcome," Mrs. Betty Lou Willey, President of MSMAS—Ballroom
Business Meeting—Members only
For non-members—Film, "A Calf, An Egg, and a Horse," courtesy of Eli Lilly Co.—Russet Room
11:30 View Exhibits—Convention Room

Afternoon Session

P.M.
12:30 Luncheon—Ballroom
Hostess—Mrs. Julia Irwin
Speaker: Dr. Donald Bouma, Sociology Professor at Western Michigan University, Kalamazoo
Topic: "The Importance of People"
2:00 Detective George Kerr of Michigan State Police Rackets Squad—Ballroom
Topic: "Narcotics—Office Rules and Regulations"
3:00 Film, "Assist for the Medical Assistant"—Ballroom—Panel discussion following film
4:00 View Exhibits—Convention Room

Evening Session

6:30 Social Hour—Courtesy of Medical-Dental-Hospital Bureau—Mezzanine and Palm Room
Music by Hammond Organ Company
7:30 Banquet—Hostess: Miss Donna Hislop
Speaker: Mr. Donald Hall, Department of Trade and Guest Relations of Upjohn Company
Topic: "Ethics for the Medical Assistant"
Dinner Music by Hammond Organ Company

THURSDAY, SEPTEMBER 28, 1961

Morning Session

10:00 *Speaker:* Harold E. DePree, M.D.—Ballroom
Topic: "Cardiac Catheterization"
11:00 *Speaker:* Edward Heneveld, M.D.—Ballroom
President-Elect of Muskegon County Medical Society
Topic: "Experience with the Kerr-Mills Bill"

Afternoon Session

P.M.
12:30 Presidents Luncheon—Ballroom
Hostess: Miss Catherine LaPres
Installation of New Officers
Presentation of Certificates for In-Service Training Program
Presentation of Charters
Style Show—Fashions for the Medical Assistant—Courtesy of Grossman Department Store
2:30 View Exhibits—Convention Room

Please mail check or money order with reservation for luncheons and banquet to: Miss Donna Hislop, 878 Second St., Muskegon, Michigan.

DEADLINE FOR RESERVATIONS: September 15, 1961. No refunds on any reservations canceled after Tuesday, September 26, 1961.

Wednesday Luncheon (tax and tip included)	$ 2.75
Wednesday Banquet (tax and tip included)	5.25
Thursday Luncheon (tax and tip included)	2.75
Registration fee for non-members	5.00

Annual Reports

ANNUAL REPORT OF THE COUNCIL, 1960-61

The Council met as a whole nine times during the past year, covering twelve days of meetings (prior to September 25, the date the 1961 Annual Session convened.) Some 950 items were considered by the full Council.

Membership

Membership as of June 30, and as of December 31, from 1935 to 1961 is indicated in the following chart:

	1935	1945	1955	1958	1959	1960	1961
June 30	3,410	4,425	5,503	6,175	6,461	6,660	6,639
December 31	3,543	4,686	6,109	6,638	6,652	6,714	

The Scientific Side

The scientific achievements of the Michigan State Medical Society continue to be its greatest benefit to MSMS members and through them its greatest service to the public. During the past year, these scientific activities included:

(a) The outstanding program of the MSMS 1960 Annual Session, which in Detroit last September, attracted a registration of 4,094 including 2,266 M.D.s.

(b) No Michigan Clinical Institute was better received by the medical profession of Michigan and neighboring states than the 1961 refresher course held in Detroit last March. Attendance was 2,626 including 1,450 M.D.s (190 more M.D.s than at the 1960 MCI). Attendance at the closed circuit color television programs was eminently satisfactory to the MCI Committee and to Smith, Kline & French Laboratories, the sponsors; also attendance at the 8:00 a.m. Discussion Groups was far greater than anticipated.

(c) The extra-mural postgraduate courses, sponsored by the Michigan State Medical Society, the University of Michigan Medical School and Wayne State University College of Medicine, continue to help maintain the Society's high scientific standing among the states.

(d) The Journal of the Michigan State Medical Society holds its position as a leader among state medical journals and is truly a scientific publication of distinct merit.

(e) The Presidents Program, approved by the 1960 House of Delegates, includes numerous scientific impacts on the medical profession, on other scientific societies affiliated with or ancillary to the Michigan State Medical Society, which are for the benefit of better health of the people. The impact of this five-year program is one that will be felt gradually, with the effort culminating in 1965 coincident with the One-Hundredth Anniversary of the founding of the Michigan State Medical Society.

(f) The 55 component societies are again commended for their quality scientific programs held at regular meetings, and especially at special clinics and other types of scientific "days."

Finance

The new headquarters building is completed and the contractor and architect are paid except for a retainage pending final adjustments. The former building at 606 Townsend has been sold at a slight gain over its value as carried on our books.

We have one note of $50,000.00 at present but expect to borrow $150,000.00 more by the end of the year. We have saved $1,600.00 in interest by paying off two notes as dues accumulated.

The Public Relations Account has a reserve of $35,000.00 in Government Bonds; however, the emergency meeting of the House of Delegates in April of this year authorized the spending of $10,000.00 of this amount.

The General Fund Reserve of approximately $22,000.00 in Government Bonds is being maintained for emergencies.

The amount of $15.00 of the dues of each member will be allotted to the New Headquarters as directed by the House of Delegates. This should result in retirement of our indebtedness in *five to six years.*

Most of our committees are well within their budgets to date but The Journal is expected to show a loss due to reduced advertising. Economy is being practiced by all departments.

The Journal

In 1960, The Journal of the Michigan State Medical Society completed Volume 59, a total of 700 issues, the first volume having been started in September and thus having only four issues. Occasionally during recent years, The Journal has adopted a new form or arrangement and for the last two or three years has been undergoing a gradual change in appearance, type faces and forms. The size has remained the same. In early years, securing original papers was a serious problem. It had been anticipated that the papers read at the Annual Meeting and some of those read at the County Society meetings would supply sufficient material, but that did not prove out. Sometimes the editorial staff had to solicit papers by personal effort.

About fifteen years ago we had the idea to

devote certain numbers of The Journal to some special interest. We started producing memorial numbers for two or three of our members, also honoring the University of Michigan and Wayne State University as medical education centers, and asked them to contribute articles to our designated issues. This interest spread to tuberculosis, cancer, rheumatism and arthritis, mental health, also to various county societies such as Wayne, Washtenaw, Kent, Genessee, the Coller-Penberthy Clinic at Traverse City, the Upper Peninsula Medical Society. We have continued that program and find that it produces all the material we could use.

At a conference of editors about a year ago, one of the top questions of discussion was how to secure original articles for state medical journals and other district or specialty journals. In Michigan we have been blessed with an abundance of material. During the year 1960, The Journal published 1,912 pages of text and advertising, also three supplements: the Roster of Committee Personnel (8 pages), the Proceedings of the House of Delegates at its September meeting (76 pages) and the Annual Directory (148 pages) making a grand total of 2,144 pages.

In the late summer of 1960, it became evident that we must curtail expenses, because the advertising which we had been depending upon for so many years began to fall off—about 37 per cent in the latter months of the year. At that time we began curtailing the extensive reports and many of the original articles, hoping this period would be temporary. We cut down the size of The Journal by 24 pages or more.

In 1960. we had a total of 202 authors and published numerous items, Society reports, special reports, 58 editorials and 28 editorial comments, 16 legal opinions and 11 presidential pages. Most of the individual numbers were sponsored by or dedicated to specific interests of the Society; they were Congestive Heart Failure, Michigan Health Council, Memorial to L. Fernald Foster, M.D., Cancer, Aging, Michigan Medical Service, Annual Session, The Kalamazoo Academy of Medicine, Mental Health, Diabetes, Heart, Child Welfare, and Mental Retardation.

The January 1961 number was devoted to the Michigan Clinical Institute. In addition to the programs, we had the supplement of the Proceedings of the House of Delegates and the Supplement Roster of the Committees. J. P. Gray, M.D., of Detroit, with his Committee spent many months assembling material of the February issue devoted to Medical Writing. The Committee studied every paper and sent it to the editor almost completely edited. March was Arthritis and Rheumatism, and J. J. Lightbody, M.D., of Detroit, secured an abundance of material for us. H. J. Vandenberg, Jr., M.D., Detroit, assisted in developing the material for the April Cancer Number. The May Journal was devoted to the dedication of our new headquarters building in Lansing. For the Michigan Medical Service issue in June, G. Thomas McKean, M.D., and Gordon Goodrich and their staff supplied the technical material. The June Number was the culmination of 13 years in which this particular Number has been devoted to Michigan Medical Service. The July issue was devoted to the Annual Session. August was devoted to Ophthalmology; Robert Crossen, M.D., Detroit, assembled much fine material for that issue. September was assigned to Otolaryngology and V. E. Cortopassi, M.D., Saginaw, has assisted in gathering that material. October will be devoted to Aging and in November, John Bielawski, M.D., Detroit, will again assist us with the Heart Number. The December 1961 Number will be devoted to the Calhoun County Medical Society.

We have been made aware of the very material shrinkage of our advertising space. Immediate compacting is almost impossible. All of these special numbers mentioned are under way and require months of work by our coordinators in assembling papers. The finished papers must go to the printers 60 days before The Journal date number. We have three numbers in process at all times and material for at least three more is accumulating. We are making every effort, however, to get the best material possible and hold The Journal down as closely as we can to a proper balance of advertising and text pages. This will be difficult because during the years we have developed a feeling that we could use many papers, and have accepted many for publication when and if we could use them. Cutting down will be difficult and we hope not too embarrassing. We have already declined several very promising papers and sent some others back to be reduced in size.

We wish to thank the Publication Committee for its cooperation and sympathetic assistance in the many problems which must be solved. The work has been enjoyable and stimulating. We also wish to thank the coordinators of our various numbers who have given tremendous help in our work.

Organization

1. Communication between The Council and members of the House of Delegates was continued mainly through Councilor Conferences and through the mailing of minutes of all Council meetings to those Delegates who requested them.

Recommendation No. 1 on this subject follows.

2. The Awards Dinner was held in Lansing on January 28, 1961 to recognize national medical and health leaders as well as organizations in Michigan which contributed outstanding service to better health for the citizens of this State. The awardees were:

Charles H. Frantz, M.D. Grand Rapids, Presi-

dent, Clinical Orthopedic Society; Martin H. Hoffman, M.D., Detroit, President, Central Neuropsychiatric Association; C. Paul Hodgkinson, M.D., Detroit, President, American College of Obstetricians and Gynecologists.

Mrs. Wm. G. Mackersie, Detroit, President, Woman's Auxiliary to American Medical Association.

Radio Station WUOM, Ann Arbor, for programming special public service broadcasts on health subjects; Jackson Citizen Patriot for excellent cooperation with Jackson CMS, AMA, etc., in printing medical news.

Jack Pickering for many years of excellent reporting medical news for *Detroit Times;* Dirk Gringhuis, Lansing, artist, for his excellent work on JMSMS covers; Marvin Niehuss, Ann Arbor, for rendering service to the University of Michigan School of Medicine—as Dean of Faculty, University of Michigan and President of the Michigan Health Council; Charles R. Sligh, Jr., Holland, Chairman of the Board of the Deafness Research Foundation.

3. The annual County Secretaries-Public Relations Seminar was held in Lansing on January 28-29, 1961. A total of 138 county and state society officers attended this worthwhile leadership-training meeting at which valuable information on socio-economic matters was imparted.

4. The Residents-Interns-Senior Medical Students Conference was featured on March 9 during the Michigan Clinical Institute. The Council has authorized a reappraisal of this Conference with a view to reaching more of the future doctors of the State.

5. General meeting at Annual Session. A short General Meeting of the Society entitled "Officers Night" held at the last meeting of the House of Delegates in September, 1960—at which time the incoming President was inducted into office—was a decided improvement in the organization of MSMS, and should be continued.

Recommendation No. 2 on this subject follows.

6. New Handbook for component societies' secretaries. This worthy publication, listing the responsibilities and opportunities of secretaries of component societies, was developed during the past year to complement the previous MSMS manual "So You've Been Elected." Distribution of the Secretary's Handbook was made at the County Secretaries-Public Relations Seminar in January, 1961. A special luncheon for new secretaries was held immediately prior to the opening of the Seminar.

7. The Relative Value Scale for Michigan was presented to The Council on July 12, 1961, after three years' study. Special commendation goes to the RVS Committee for its industry and high devotion to duty. The personnel includes: L. R. Leader, M.D., Detroit, Chairman; F. C. Brace, M.D., Grand Rapids; H. T. Caumartin, M.D., Saginaw; A. J. Day, M.D., Grosse Pointe Farms; H. A. Furlong, M.D., Pontiac; R. A. Johnson, M.D., Detroit; and A. J. Neerken, M.D. Kalamazoo.

Recommendation No. 3 on this subject follows.

8. Articles unfavorable to Medicine, appearing in increasing number in magazines across the land, were discussed by The Council which sought advice from the AMA. When unfavorable articles appear, AMA protests generally are made face to face with the editors involved as well as through letters signed by AMA officials. Since an increase in the number of articles involving medicine can be expected because of the present spotlight involving health care of the aged, The Council feels that protests also should come from our own Society and its important "grass roots."

Recommendation No. 4 on this subject follows.

9. Other organizational improvements inaugurated during the past year were: American Medical Education Foundation awards of merit were sent to the appropriate component societies for presentation to members; AMEF checks to the two medical schools in Michigan were presented through the Michigan State Medical Society at the June 4 dedication of the new MSMS building; the Advisory Committee to the Executive Director was made a standing Committee of The Council in November, 1960; and index of The Council's major actions, in addition to the current cataloging of policy decisions, was inaugurated during the past year; Council proceedings were expedited during the past year by mimeographing some of the Officers' and staff members' reports, and a plan was developed to expedite agenda presentations to keep pace with the increased business placed before The Council (an indication of the greater scope of activity of your State Society); the Directory of Members is to be published biennially, in the even numbered years, to save expense.

10. Obtaining speakers for component society meetings, giving guidance on scientific, legal and socio-economic questions, and helping to solve administrative and ethical problems continue to be important services which the State Society is rendering to its 55 components.

Contacts with Governmental and Voluntary Agencies

The maintenance of contacts with both governmental and voluntary agencies represents a major and important department of your State Society's work.

Governmental Agencies

1. The University of Michigan's Study of Hospital and Medical Economics, including Blue Cross and Blue Shield (the McNerney Report), financially sponsored by the Kellogg Foundation at a cost of $380,000, was completed recently after more than three years' work. This subject was considered at every meeting of The Council during

the past year. The Council requested that a copy of the information released to the Governor's Commission be released simultaneously to the Michigan State Medical Society as well as to the Michigan Hospital Association, Michigan Hospital Service, Michigan Medical Service, and others. The Education Liaison Committee was urged to do all in its power to implement necessary follow-through to secure prompt release of this report to MSMS members.

The Medical Care Study Committee thoroughly considered this matter and stressed the pressing need for MSMS to retain a staff economist and to obtain the services of special consultant economists to evaluate the U-M study. A preliminary evaluation of the two published sections of the report, to ascertain if there is need for a more complete and detailed study, was authorized by The Council on April 19. Professor C. T. Hardwick, Director, Institute for Business Services, University of Detroit, was engaged to develop a report for the July Session of The Council.

Recommendation No. 5 on this subject follows.

2. Health care of the aged. Both the federal and state governments have indicated great interest in this subject during the past year, with gross political connotations apparent before and since the November election. Following the AMA Legislative Conference of March 18-19 in Chicago, The Council called an emergency meeting on March 26 to discuss the implications of HR 4222 in the federal Congress, which proposes health service to the aged through the Social Security System. To develop and implement a necessary informational campaign to the public through MSMS members, The Council requested the Speaker of the House of Delegates to call a special session to consider action on this problem, which Session was held in East Lansing on April 16. As you all know, seven work groups discussed (a) Financing the program; (b) Communicating with doctors; (c) County medical society programs; (d) Media; (e) Legislative contacts; (f) Working with others; and (g) Establishment of position and policy of Michigan Medicine. Each group offered recommendations in its category which, as amended, were adopted by the House of Delegates.

As of the present moment, the situation in Washington has been slightly altered by the House of Representatives insistance that hearings on HR 4222 and similar proposals be scheduled. During this period of momentary "quiet on the western front," your State Society has proceeded with the April 16 House of Delegates plan, including four regional meetings, an information mailing to all MSMS members, preparation of a printed brochure, development of a speaker's bureau, etc. But it is the better part of valor to hold most of the fire until the picture becomes less opaque, until the Washington strategy is more clear. Meanwhile, the Michigan State Medical Society has requested that its representative (O. K. Engelke, M.D.) be invited to present testimony at the hearings in Washington, D. C., and the complete implementation of the House of Delegates program is being scheduled by the Public Relations Committee.

In this connection, The Council feels this is the time we must *accentuate the positive.* Medicine must take the offensive and tell about the fine work of the medical profession—we must be a challenging profession—we must sell medicine—we must contact morale-breaking opponents with dignity, showing them and all others that it is much more difficult to be a doctor of medicine now than formerly and that we have a great profession. We must improve the collective image of the medical profession by aggressive presentation of Medicine's viewpoints.

The good that Medicine has done in its glorious history and is doing today, with the United States offering the best health care in the world, must be expounded over and over and over to the people by doctors and their friends. This profession has everything to be proud of, its accomplishments are glorious, its future bright! No other organized group can claim more, and few can claim as much in the field of service to the public. Further. medical men must realize that the best organizations doctors have to defend Medicine, as we know it, is their county, state, and national societies and must stand unified behind them. *Accentuate the good* that we have and are doing!

Recommendation No. 6 on this subject follows.

3. As in 1960. The Council presented testimony at the Michigan Insurance Commissioner's hearings on Blue Shield's request for a rate increase. Good publicity for the medical profession resulted from the affirmative position taken by the State Society and the presentations made by H. J. Meier, M.D., at the Detroit hearing, February 7, 1961; by Clarence Beets, M.D., at the Grand Rapids hearing, February 15, 1961; and by Kenneth H. Johnson, M.D., at the Lansing hearing, February 16, 1961.

4. White House Conference on Aging. The State Society was ably represented at this Washington, D. C., Conference by Albert E. Heustis, M.D., Lansing; Max K. Newman, M.D., Detroit; C. J. Tupper, M.D., Ann Arbor; V. K. Volk, M.D., Saginaw; H. B. Zemmer, M.D., Lapeer. The determined efforts of proponents of socialized schemes were countered in part by the understanding and skill of Medicine's representatives at this important meeting. The vital value of well informed, well organized effort on the part of Medicine was graphically illustrated at this well publicized Conference.

5. Proposed Institute of Biology and Medicine. The Council's Education Liaison Committee (B. M. Harris, M.D., Chairman) has met on several occasions with Michigan State University representatives who are studying the possibilities of

creating such a two-year Institute on the East Lansing campus. The plan is now in the exploratory stage; new developments as they emerge will be presented to the House of Delegates for its information.

6. The Michigan State Medical Society continues to have beneficial contacts with other governmental agencies including (a) the Michigan Legislature; (b) Michigan Department of Health with Commissioner A. E. Heustis, M.D., invited to all meetings of The Council; (c) Michigan Department of Public Instruction and its Office of Vocational Rehabilitation; (d) Michigan Department of Social Welfare; (e) Michigan State Board of Registration in Medicine; (f) Michigan Crippled Children Commission; and (g) University of Michigan Medical School and Wayne State University College of Medicine with the Deans of each being invited to all meetings of The Council.

Voluntary Agencies

1. Periodic reports on the progress of Michigan Medical Service are made to The Council by MMS President G. Thomas McKean, M.D., Detroit. The new Executive Vice President, Sumner G. Whittier, was introduced to The Council at its March 7 meeting on which occassion the MSMS position with Michigan Medical Service was thoroughly discussed. In essence, The Council feels that the medical profession of Michigan does and must stand behind Michigan Medical Service which is an instrument of good for the people of Michigan; physicians may well ask the question: "Has anything *better* been created?"

2. The American Medical Association continues an aggressive program against proponents for socialized medicine. In a word, all MSMS members should be proud of AMA, willing to work in its ranks and to support it in its efforts for the preservation of medical practice as we know it.

3. Your State Society continues to encourage the Student American Medical Association and urges more individual doctors of medicine to offer guidance, especially in socio-economic matters, to those future physicians of the nation. SAMA has given these young men and women a good foundation in the principles of practice in which we believe; but beneficial contacts with practicing M.D.s is necessary to imprint on their impressionable young minds that a collectivist system of medical service to the people would quickly ruin quality medical care.

4. Statement of policy re podiatry. Recent contacts were made with the Michigan Association of Orthopedic Surgeons and the Detroit Academy of Orthopedic Surgery enlisting their comment re MSMS statement of policy on podiatry which embodies the principles set forth in the statement of the American Academy of Orthopedic Surgery and the Joint Commission on Accreditation of Hospitals. If approved by the Michgan groups, the statements re podiatry will be presented to the House of Delegates for its consideration.

5. Mutually beneficial contacts continue to be maintained with the Michigan Heart Association, Michigan Hospital Association, Michigan State Dental Association, Michigan State Nursing Association, Michigan League for Nursing, Michigan Practical Nurse Association, Michigan State Pharmaceutical Association, Michigan Hospital Service, Michigan Medical Service, Michigan Branch of Health Insurance Council, Michigan Health Officers Association, with the six other Michigan organizations interested in cancer control through the Michigan Cancer Coordinating Committee, Michigan Livestock Health Council (interested in animal diseases communicable to man); Michigan Association of the Professions, and the Michigan Health Council (which is to be especially commended on its excellent health conference held in Flint in May, which on one day featured the MSMS Presidents Program).

Committees

A total of eighty-six meetings of Committees of (a) the House of Delegates, (b) the Michigan State Medical Society, and (c) The Council were held during the past year (up to August 31, 1961). Additionally, twelve meetings of liaison committees to which MSMS sends official representatives, were held during the past year. The structure and activity of your State Society committees continue to be the core of MSMS progress. Committee members, therefore, deserve high praise for their almost anonymous contributions to all MSMS members and through them to the public.

1. Special commendation goes to the Big Look Committee which successfully guided the erection of the new MSMS headquarters building in East Lansing—the zeal of Chairman W. S. Jones, M.D., of Menominee and MSMS President K. H. Johnson, M.D., of Lansing, must be recognized.

2. The increasing importance of the Committee on Recruitment for Medical Careers, headed by Glenn E. Millard, M.D., of Detroit, exemplifies the high interest of your State Society in finding the best qualified young men and women to enter the medical field. Several MSMS representatives participated with the Michigan School Counselors Association in a Career Information Workshop, July 7-8 at Alma College. Here is an opportunity for every member of the Michigan State Medical Society, especially the members of the House of Delegates, to give tangible help. The quality of those seeking a career in Medicine is now as good as ever but the numbers are not as generous as ten years ago, due in part to the recent glamour of other scientific callings. Grass root contacts by individual M.D.s is necessary to maintain Medicine's place in the career's sun.

3. To save time for members of the House of Delegates Reference Committees, the Annual Reports of Committees of The Council are annually

integrated into this report of The Council:

A. *Big Look Committee.*—As in previous years, the Big Look Committee continued to supervise the construction and furnishing of the new MSMS headquarters as instructed by The Council.

Continuing liaison with the architect, the general contractor and various subcontractors was maintained by various members of the Committee, especially Kenneth H. Johnson, M.D., of Lansing, who was appointed Lansing contact representative of the Committee.

Between President Johnson and the Chairman, many decisions of the Committee were resolved by consultation through letter and telephone during the year.

On January 28, 1961, in East Lansing, the Big Look Committee held its one formal meeting to develop specific plans and program for the dedication ceremony which was subsequently held on Sunday, June 4, 1961.

The Committee emphasized that the dedication, printed program and the presentations by officers of the Society should emphasize the doctors' desire to serve the people of Michigan and that this service could be increased through the use of the new and functional MSMS headquarters.

As one of its last duties, members of the Committee, on June 4, gave a final inspection to the headquarters building and the resulting comments were submitted to the architect for any necessary action by the general contractor.

Having fulfilled its purpose and completed its work, the Big Look Committee respectfully recommends that it be discharged.

The Chairman wishes to extend special thanks to each member of the Committee who so faithfully and conscientiously served in behalf of all Michigan State Medical Society members.

B. *Michigan Chairman, American Medical Education Foundation.*—Again this year, the Michigan State Medical Society's dues notice sent to all members contained a request for a voluntary contribution to the American Medical Education Foundation.

In addition, the American Medical Education Foundation sent a direct appeal for contributions to every member of the American Medical Association in May, 1961.

From reports of AMEF and the MSMS, it is obvious that most contributions to AMEF from Michigan physicians and friends of medicine are sent directly to the AMEF in Chicago.

This year, at the dedication ceremonies of the new MSMS headquarters on Sunday, June 4, 1961, at East Lansing, AMEF checks totalling $26,286.54 were presented to the Deans of the University of Michigan Medical School and the Wayne State University College of Medicine. These checks represented contributions from the nation's doctors that were designated to Michigan medical schools, plus undesignated contributions to AMEF which were apportioned equally among all medical schools.

Included in the above totals were contributions of Michigan physicians as a result of the MSMS dues notice appeal. These checks were made out to AMEF, sent to MSMS, and forwarded to the Chicago office. For the period January 1, 1961, through May 30, 1961, 142 members of the Michigan State Medical Society had contributed a total of $1,980 to AMEF through the MSMS office.

The AMEF committees of the Woman's Auxiliary to the MSMS have continued their excellent activity with their contributions going directly to the AMEF.

Your Chairman this year recommended that there be an increase in MSMS dues or an allotment from present dues for a special AMEF fund. This was similar to a resolution placed before the House of Delegates in 1958, which was not adopted, for the House believed that all contributions should be made on a voluntary basis.

Your Chairman is pleased to report that the AMEF checks to Michigan medical schools were given the broadest possible publicity this year, on the occasion of the dedication of the new MSMS headquarters, and recommends that similar public presentations be made in future years as the opportunity presents itself, so that the public may be more aware of the support the physicians of the United States are lending to medical education.

C. *Committee on Disaster Medical Care.*—The appointment of Max Lichter, M.D., to the chairmanship of the American Medical Association Committee on Disaster Care prompted his resignation from the Chairmanship of this Committee in the middle of the year. Doctor Lichter has devoted many years to local, State, and National activities in this field, and his present appointment is highly deserved.

The Committee, in its normal activities, completed plans for a spring tour of components of the 200-bed Emergency Hospital under the joint sponsorship of the Michigan Office of Civil Defense.

By the experience gained in getting the components of the 200-bed Emergency Hospital on the road, the Committee aided the MOCD in getting out a Manual of Instruction in how to open up these hospitals for functional use. This was published by the MOCD in May, 1961.

A periodic civil defense newsletter was prepared and mailed to all of the members. The Committee received information about training courses for nurses in the State in the use of the 200-bed Emergency Hospital. Plans for a civil defense exhibit have been submitted to The Council for approval at the September meeting in Grand Rapids. It also prompted, in coordination with the Michigan State Pharmaceutical Association, a survey of available medical and surgical supplies.

The second Annual Physicians' Hospital Workshop on Civil Defense was held in Battle Creek on May 17 and attended by 102 representatives of local societies and hospitals in civil defense.

D. *Committee on Courses on Medical Economics and Ethics.*—The year has been vigorous

and productive, and we gratefully acknowledge the contributions of our Committee members, visiting dignitaries, lay and professional speakers, the faculties and members of the Senior Medical Class, University of Michigan.

Dr. Richard Bing, this year, is Chairman of the Student Faculty Assembly, Wayne State University College of Medicine, Detroit, and he has kindly volunteered to reflect the work at that school. He has been requested to write you direct.

SCHEDULE OF LECTURES BEFORE THE UNIVERSITY OF MICHIGAN SENIOR MEDICAL CLASS

1. 7/ 6/60 "Development of a Fee Schedule," by C. Howard Ross, M.D.
2. 7/20/60 "The Surgeon and His Fee," by Charles G. Child, M.D.
3. 7/27/60 "The Veterans Problem," by William Bromme, M.D.
4. 8/30/60 "The Morality of Surgery," by Thurston Thieme, M.D.
5. 8/17/60 "Ethics Involved in George Washington's Death," by Darrell Campbell, M.D.
6. 8/31/60 "The Physician's Responsibility to the Community," by Richard C. Bates, M.D.
7. 9/14/60 "Hospital and Medical Economics," by Prof. W. J. McNerney
8. 10/ 5/60 "Ten Easy Lessons on How to Land in Court," by Lester P. Dodd, Attorney, Michigan State Medical Society
9. 10/12/60 "Continuing Education in Medical Ethics and Economics," by William Hubbard, M.D., Dean, U. of M. Medical School
10. 11/16/60 "The Doctor's Accounting System," by C. Howard Ross, M.D.
11. 11/30/60 "The Doctor in Court," by Judge James R. Breakey, Jr.
12. 12/ 7/60 Panel—"Orientation, Between General Practice and the Specialties"
 (a) "Introduction and Moderator," C. Howard Ross, M.D.
 (b) "General Practice and the Specialties," by Howard Robinson, M.D.
 (c) "General Practice in a Metropolitan Area," by Lyle Korum, M.D.
 (d) "Consultation Techniques," by A. C. Stander, M.D.
 (e) "Art of the Practice," by F. P. Rhoades, M.D.
 (f) "The Family Physician's Place in the Community," by Russell Fenton, M.D.
 (g) "General Practice—The Keystone," by Howard Rees, M.D.
 (h) "Medical Organization," by E. Clarkston Long, M.D.
13. 12/14/60 "A History of Ethics," by C. Howard Ross, M.D.
14. 1/18/61 "Michigan State Medical Society," by Otto K. Engelke, M.D., President-Elect, MSMS
15. 1/25/61 "A Doctor Walks Among Many Religions," by Winslow G. Fox, M.D.
16. 2/ 1/61 "An Ethical Approach to Geriatrics," by C. Howard Ross, M.D.
17. 2/ 8/61 "Ethical Relationship Between Public Health and the Practice of Medicine," by Myron Wegman, M.D., Dean, School of Public Health, Univ. of Michigan
18. 3/ 8/61 "The Ethical Problems of Race Explosion, Contraception and Therapeutic Abortion," by Panel: John Sheldon, M.D., William Hubbard, M.D., and David G. Anderson, M.D.
19. 3/ 5/61 "Duo Versus Singleton Practice," by Robert Kanauer
20. 4/ 5/61 "Medical Manpower," by A. C. Furstenberg, M.D., Dean Emeritus, Univ. of Michigan Medical School
21. 4/12/61 "Orientation Committee, Washtenaw County Medical Society," by Panel, conducted by: John M. Sheldon, M.D., Chairman, Edmund S. Botch, M.D., Moderator, R. Wallace Teed, M.D., Theodore G. Kabza, M.D., and Gerhard H. Bauer, M.D.
22. 5/10/61 "Medical Placement in Michigan," by Sidney Chapin, M.D., President, Michigan Health Council, R. W. Spaulding, M.D., John E. Doherty, Executive Secretary, Michigan Health Council
23. 5/17/61 Panel—"Medical Communication and Public Relations"
 (a) "Confidences Between Doctor and Patient," by C. Howard Ross, M.D.
 (b) "Public Relations," by R. Wallace Teed, M.D.
 (c) "Medical Communications," by Mr. Hugh Brenneman
 (d) "A Doctor's Niche in His Own Community," by Stuart M. Finch, M.D.

We had a very good attendance through the entire year and some students took notes for their confreres, who externing elsewhere.

E. *Liaison Committee with Michigan Veterans Organization.*—Only one problem has been presented during the past year. This concerned alleged prescribing for a service-connected condition without authorization by Veterans Administration.

Preliminary study has not warranted a call for a committee meeting.

F. *Committee on the Recruitment of the Superior Medical Students and Their Need for Financial Aid.*—The Committee held one meeting in March of 1961. Prior to this it was a Subcommittee of the Public Relations Committee. The first meeting of the Committee was for the purpose of studying the problem of recruitment on one hand and of financial aid on the other. Invited in the discussion were representatives of the Deans of the two Medical Schools. Our study showed that only six out of the fifty-five county medical societies have any loan or scholarship program.

The Michigan Foundation for Medical and Health Education has so far refused to disclose any details of the amount or number of scholarships which they have. The Deans report that the demand for positions in medical school now is only about equal to the number of positions available, also, that there is a sort of competition developing between the medical schools for exceptional medical students—particularly by the medical schools in the East.

The recommendations following the last meeting of this Committee were:

1. That a letter be prepared under the supervision of the Chairman of this Committee urging each county medical society to set up a scholarship or loan fund and that this be followed by a

letter requesting a personal visit to a meeting of each county medical society by a member of this Sub-committee, a member of SAMA, and when possible, by a representative of the Dean of one of the Medical Schools to assist in the implementation of the formation of this scholarship loan fund on a county basis.

2. The Committee recommends to the Michigan Foundation for Medical and Health Education Incorporated, that a re-study of their loan and scholarship provision be made for the purpose of considering liberalization of these provisions in the area of (a) geographical restriction of applicants, (b) re-payment and (c) rate of interest, (d) ultimate location of practice.

The Committee has the feeling that the alumni societies of the two Medical schools have not done a good job in scholarship and loan programs. A further study is contemplated in this area.

It is obvious that neither the county societies nor the State Medical Society has done a good job in this area.

G. *Committee to Study Problems of Emergency Care in Hospitals.*—The Committee met on May 23, 1961. It was largely an organizational meeting, in which the work of a similar committee of the Wayne County Medical Society was reviewed and this Committee's plans were formulated.

The discussion of hospital emergency care revealed the fact that serious problems exist throughout the state requiring investigation.

The Committee requested The MSMS Council's permission to make a survey of accredited hospitals in the state, through the chiefs of staff, regarding their problems in handling emergency medical care.

If this request is approved by The Council, the Committee will meet to develop a questionnaire.

H. *Medical Care Insurance Committee.*—The MCIC has been mainly concerned during the past year with the report of the Relative Value Study. We have had two joint meetings with the RVS Committee as well as attending the final meeting with all specialty groups.

The Relative Value Study has now been approved and transmitted to The Council for further action. We have also followed closely the predicament of Michigan Medical Service and we are interested in the new contracts which are being considered by the Michigan Medical Service Board of Directors.

Annual Report of Sub-Committee on Relative Value Study, 1960-1961.—Recommendations of the Relative Value Study Sub-Committee are incorporated in the "Proposed Michigan Relative Value Scale" which will be presented to the 1961 House of Delegates.

It was during 1960-61 that the Relative Value Study Sub-Committee completed its work. Organized in December, 1958, the committee met for 34 separate days of meetings and conferences to develop a list of proposed relative values.

After its mail survey in early 1960, an independent, professional analysis organization compiled and tabulated the material. It was certified by a statistical consultant as being valid.

The Committee, using this data, then held hearings and consultations with the officially-chosen representatives of the various general and specialty groups of doctors in Michigan. The tentative RVS report was furnished to all the various medical organizations and an open hearing was held in February, 1961. Some final changes were made and the report was presented to the Medical Care Insurance Committee in April. MCIC presented the report to The MSMS Council in June.

No one on the committee realized how enormous this task would be. In addition to the committee meetings and conferences, many hours were spent on "homework" between sessions. This is mentioned only to indicate the careful analysis and study which was required in this project. Cooperation from individual doctors and from the various medical organizations was excellent.

I. *MSMS Representatives to Liaison Committee with Michigan Society of Neurology and Psychiatry and Michigan Psychological Society.*—There were no meetings held between the Liaison Committee and the Michigan Psychological Society. As indicated in our report last year, the members of this Committee have been kept up-to-date regarding the devolopments in this particular area since we also are members of the MSMS Committee on Mental Health.

Reports of liaison committees, to which MSMS sends representatives, were presented monthly to The Council for its information.

Legal Matters

Your Legal Counsel, Lester P. Dodd, LL.B., of Detroit, attended practically all meetings of The Council and of the House of Delegates and attended and participated in the County Secretaries-Public Relations Seminar, the MSMS Annual Session, and the Michigan Clinical Institute.

Legal Counsel attended many committee meetings and participated actively in the work of the Legal Affairs Committee, the Committee on Utilization of Practical Nurses, all committees pertaining to insurance, and the Committee on Revision of the Constitution and Bylaws (the latter being extraordinarily time consuming). He visited and addressed several county societies and other professional organizations.

Mr. Dodd has done considerable research and investigation with respect to adoption of a single practice act, retirement plans and Kintner-type legislation. He rendered six formal and fifty-six informal opinions on a wide range of subjects. He handled many legal problems arising out of the

construction and furnishing of the new headquarters building.

Finally, Mr. Dodd counselled with officers and staff on innumerable details on the Society's operations.

New MSMS Headquarters Building

At every meeting of The Council, a report on the progress of the new building including furnishings and new equipment, and sale of 606 Townsend in Lansing (sold for cash on May 15, 1961) was presented by the Lansing representative of the Big Look Committee, President Johnson.

The raw building was completed and certified for occupancy by the architect and the Society moved into the headquarters at 120 W. Saginaw Street, East Lansing, on April 24.

Gifts to aid in the furnishing of the building were gratefully received from Mrs. L. Fernald Foster and family of Detroit, in memory of our long-time Secretary, the late L. Fernald Foster, M.D.; from Mrs. Ralph W. Shook and family of Kalamazoo, in memory of our long-time Finance Chairman, the late Ralph W. Shook, M.D.; from Big Look Chairman and Mrs. W. S. Jones, Menominee; from the Past Presidents to decorate the Presidents' Room; from the Woman's Auxiliary to furnish the All Purpose Room; from Bruce Publishing Company of St. Paul; and Wellman Press of Lansing. Small plaques, to memoralize these generous gifts, have been placed in appropriate rooms of the new building.

The dedication of the building on June 4 was a happy occasion, blessed with perfect weather, a large and sparkling attendance, and a ceremony befitting this great occasion. A copy of the dedicatory booklet, including the program of the day, is respectfully submitted with this report.

Every member has reason to be proud of the Michigan State Medical Society and its century of accomplishment, professional dignity, and record of life saving service to mankind—all symbolized in its modern and useful headquarters building in East Lansing, dedicated to the public interest.

MSMS Group Insurance Programs

The Supplemental Annual Report of The Council will contain a complete report on the two group insurance programs of your State Medical Society with data up to September 1, 1961.

"Medicare" and Veterans Administration Hometown Medical Care Programs

1. *Medicare* (Medical care for dependents of servicemen) continues to be handled by Michigan Medical Service as fiscal agent of the Michigan State Medical Society. To date, since the restoration of some services to the program, there has been an increase in the private practice of medicine under the program. The program so far has been satisfactory both to the patients and the doctors. Michigan Medical Service has been commended for its handling of the program. During the fiscal year, $904,846.32 was paid to practicing physicians for service rendered.

2. Veterans Administration Hometown Medical Care Program. During the past year there were no changes made in the program. The contract was extended, with approval of The Council, to June 30, 1962. The Council again, in approving the extension of the contract, indicated its attitude had not changed as reported previously "unless the program for care of veterans is much improved, MSMS seriously considers discontinuing its participation."

There has been a decrease by approximately 25 per cent during the year in the number of invoices received from the Veterans Administration for physicians' services. As a result the total amount of fees for services paid by the fiscal agent has decreased.

Woman's Auxiliary

Submitted by Mrs. Paul Ivkovich, President

The most gratifying of experiences has been to be head of the auxiliary to the finest organization of men . . . the Michigan State Medical Society. During this season of Commencement Exercises, I too feel as though I were graduating after four years of service on the state level to an organization that at first was completely social and now is a most progressive organ of activities.

The Woman's Auxiliary to the Michigan State Medical Society was formally organized June 16, 1927 at Mackinac Island by Doctor Herbert Randall of Flint, then president of the Michigan State Medical Society. Mrs. Guy L. Kiefer, Detroit, was the first president with twenty-eight charter members. Her name is engraved on the official gavel of the president as a token to her memory. Today Michigan has forty-eight organized county auxiliaries, twenty member-at-large among the eight unorganized counties with a total membership of 3,275. This represents approximately half of the membership of the Michigan State Medical Society and it is our sincere hope that we may recruit more doctors' wives to belong to an organization dedicated to serve the finest profession in the world.

We wish to sincerely thank all the members of the Michigan State Medical Society for their cooperation during the past year and tell you how very happy we were to be called upon to work with you. In August of 1960, our county presidents were asked to contact their membership to work on the "Campaign for Freedom" program with you . . . the response was most gratifying. This year as in other years, your auxiliary has worked with the youth in Michigan to encourage them in the health careers. The county reports reveal formation of Future Nurses Clubs, Future Doctors Clubs and now Health Careers Clubs. Auxiliaries throughout the State raise money for scholarships for nurses and to furnish money for future doctors. Alto-

gether close to $6,000.00 has been donated in the form of scholarships and loans to individual students and to schools of nursing and medicine.

Legislation has been our main project this year. We are cooperating with the Woman's Auxiliary to the AMA, headed by our national president, Mrs. William Mackersie of Detroit, Michigan's first national president, in Operation Coffee Cup.

The Michigan State Medical Society has specifically asked the Auxiliary to work on Operation Coffee Cup at their special meeting of the House of Delegates, April 16, in Lansing. This project hinges upon the use of the record, "Ronald Reagan Speaks Out Against Socialized Medicine" in informal groups in individual auxiliary members' homes to stimulate friends and neighbors to write their congressmen. Michigan has one hundred records at this time which are being distributed throughout the State and we are pleased to report that it seems to be going over well . . . even our county medical societies are interested in this record and have used it at their county meetings. The AMA is underwriting the cost of these records. We are not planning to complete Operation Coffee Cup in a month or two months . . . we hope to continue its use for at least a year and feel confident that it will produce fine results.

We are very proud of our activities in the field of raising funds for the American Medical Education Foundation. We have increased this fund from approximately $6,000.00 in 1960 to $9,000.00 in 1961 due to the untiring efforts of our AMEF Chairman, Mrs. Rufus Reitzel of Mt. Clemens. Mrs. Reitzel attended several District Meetings and visited individual auxiliaries in the State to encourage members to either donate or raise funds for AMEF. Auxiliaries have given luncheons, had fashion shows and teas, rummage sales, bridge parties and many other activities to promote AMEF. Our goal is $5.00 per member and we hope to achieve that in the future.

Members of the auxiliary have cooperated with committees in Civil Defense and Safety. The auxiliaries' specific project has been SWAT for 1961 . . . Safe Water Activity Training.

We have an active committee on Mental Health and are pleased that you have asked one of our representatives to attend your Council's meeting on Mental Health.

We have participated in the TB Speaking Project for nineteen years. Our 1961 program was most gratifying and of the six top winners of high school students, four were young men. Our auxiliaries have invited these students to give their winning papers at their meetings which has greatly increased the interest in this worthwhile project.

I have just given you the highlights of our auxiliary year . . . our Committees work on publicity, contribute to the National BULLETIN of the AMA auxiliary, procure health programs for other organizations such as PTA, Rural Health groups and countless other organizations. Our Community Service chairman listed 150 organizations that our auxiliaries work with throughout the State.

Your auxiliary exchanges visits with the auxiliaries of Illinois Indiana, Ohio, Wisconsin, and Toronto. This year, as in other years, the state president has visited all of these states together with another officer, with the exception of Wisconsin where only the president attended. It is our opinion that having two officers visit out of state is beneficial for the incoming officers to become informed with what other states are doing and exchanging ideas that keep the auxiliary progressive.

We have divided into nine districts and therefore have nine district directors. We have tried to have each district director be responsible for one meeting a year in her locality to keep the members informed of what is going on. It would be ideal to have more members participate at the annual convention in the fall but that is not always possible due to baby sitting problems, traveling, et cetera.

The district meeting brings the state officers to the meetings and therefore that personal contact which is so important in all phases of activities.

We take time out for hobbies too. This will be the first time that Michigan hopes to have an art exhibit at the fall convention. Arrangements have been made between our Chairman of this new project and Mr. Bill Burns of our office in East Lansing and we are inviting you to participate in what may be a most interesting development by asking you to bring your works of art, et cetera, to Grand Rapids to be on display for all of us to see. Mrs. Robert Emerick of Fremont is our chairman of this art exhibit.

This report is brief . . . its touches just the barest outline of what your Auxiliary is doing and we thank you for the privilege of being your wives.

Public Relations

Public Relations activity has been intimately involved with major projects of the Society as in the past. In addition, the varied subjects involved are indicated by the following activities of the past year. It can be proudly noted that MSMS has effectively assumed leadership in coordinating the work of health, professional, and vocational associations so that an integrated program second to none in the nation has been activated.

—Nomination of Edwin L. Thirlby, M.D., for the AMA General Practitioner of the Year Award.
—Work with science writers and other newspaper representatives.
—Assistance to the Medical Assistants.
—Work with county medical societies, their Auxiliaries and their local medical assistants groups.
—MSMS exhibit at the Michigan State Fair.
—Planning and implementation of complete publicity programs in connection with the Annual Session and the Michigan Clinical In-

stitute, including TV, radio and newspaper, plus special presentations before service clubs, women's clubs, et cetera.

—Special TV programs on such subjects as medical care of the aged, the role of the family doctor, et cetera.

—Directional and cooperative services in connection with the Michigan Health Council State Health Conference, including the 13th Annual Michigan Rural Health Conference, the 3rd Annual Michigan Health Careers State Conference and the 1st Michigan Conference of the Joint Council to Improve the Health Care of the Aged.

—Special Meeting of the House of Delegates held for the purpose of discussing implications of HR 4222 which resulted in four regional meetings throughout the State to inform the doctors on this legislation. (Attendance at three of these regional meetings was disappointing.)

—Similar services were rendered in connection with the Congress of the Professions of which the MSMS Legal Counsel, Lester P. Dodd, was General Chairman, held in Detroit, February 22-23-24.

—Meetings on Public Relations on the state and national level—participated in both by attendance and as program participants.

—As instructed, developed recognition programs for outstanding services of members, science writers, ancillary personnel and a multitude of others by letter, scrolls, gifts, et cetera.

—Preparing, reviewing, and revising films and purchase of prints.

—Testifying before legislative committees and arranging for testimony.

—Active liaison with the Michigan Health Council in its day-to-day operations.

—Recruiting of medical students and medical associates via the preparation of brochures, and the holding of conferences at educational institutions and elsewhere, such as in connection with MAP Career Conferences in Saginaw and the MAP Conference with School Guidance Councilors at Alma College.

—Preparing contacts with Congressmen, Public Health Officers, public officials, and friends of medicine, both in Michigan and Washington, D. C., as well as testimony before Congressional and Legislative Committees.

—Arranging for special information to be given to members of The Council and other key persons on subjects of legislative interest.

—Assistance to county medical societies in programs, the awarding of honors, publicity, and any number of miscellaneous problems.

—Development of brochures for special purposes and articles for The Journal, MSMS.

—Maintenance of a Public Relations Library and distribution of thousands of publications.

—The taping and telecasting of a weekly series of TV shows over WJBK-TV Detroit and other channels on various medical and health subjects in cooperation with MAP and the Michigan Health Council.

—Rendered planning and promotional assistance in connection with the Presidents Program.

Legislation

Legislative activity during late 1960 and the first three quarters of 1961 has been compounded of almost equal parts of first, intensified activity in support of Kerr-Mills and against King-Anderson federal legislation, and second, the most hectic and arduous state legislative session in memory.

Federal

In anticipation of a concerted drive to bring medical care for the aged under the Social Security system by establishing the "service principle," a full-scale program is being organized to mobilize Michigan physicians in the fight against the King-Anderson Bill and Forand type legislation generally.

An MSMS delegation consisting of Kenneth H. Johnson, M.D., James R. Dehlin, M.D., Lawrence A. Drolett, M.D. Robert J. Mason, M.D., C. Allen Payne, M.D., Hugh W. Brenneman, Public Relations Counsel and M. A. Riley, Public Relations Field Secretary was also dispatched to Washington, D. C., in early May and discussed the federal socialized medicine proposal with all members of the Michigan delegation. Further, MSMS President-elect Otto K. Engelke, M.D., appeared before the Committee on Ways and Means of the United States House of Representatives in July, in opposition to the King-Anderson Bill.

State

In the State capitol the Michigan Legislature considered nearly 1,100 bills and 240 resolutions, one in twenty of which had direct medical implications. Over 80 per cent of these either died in committee or, having passed one House, died in the other. The 71st Legislature was preoccupied with taxation, appropriations, and the imminent Constitutional Convention—first in 53 years.

Legislative Reports from MSMS reflected repeated attempts by chiropractors to expand privilege and practice. House Bill 384, which would have broadened the definition of chiropractic, passed the House but died in the Senate. Senate Bill 1127, designed to license physical therapists, was preempted by chiropractic partisans by an amendment attempting to legalize all its "present practices," thus killing this bill in the House. Finally, an eleventh-hour amendment was placed on Senate Bill 1039, the Medical Aid to the Aged Bill, to make chiropractic services "medical aid" —sending the bill to two conferences between House and Senate before legislators removed the amendment and passed the bill as endorsed by MSMS.

In other areas, a bill was amended which, if

passed, would have required every physician to obtain a second "dangerous drug license" from the State Board of Pharmacy.

The Public Health appropriation was amended to permit payment of physicians' bills rendered in excess of 30 days during fiscal year 1960-61, for services to crippled and afflicted children. While the ceilings on payment to physicians under these acts, unchanged since 1948, were not raised, encouraging progress was made toward general legislative acceptance of the need to raise them in the 1962 session.

Two bills, one to establish minimal standards for ambulances and another to improve the law for testing intoxicated drivers, failed of passage although the latter passed the state Senate.

Despite appearances by ophthalmologists before both House and Senate committees and later before the Governor requesting his veto, House Bill 574 became law and confirmed the present practice of contact lense fitting as part of the definition of optometry.

Attempts to loosen the Psychologists Registration Act of 1959 met defeat in the Legislature, and new licensure laws for hospitals and for dispensing opticians died in the first committee. A bill aimed at control of cancer quackery, House Bill 44, was deferred pending further study of similar legislation in three other states.

Three resolutions of particular interest were passed creating special study committees—one of the Blue Plans, one of the optical sciences, and one of the Crippled and Afflicted Children Acts.

Matters Referred for Action by the 1960 House of Delegates

1. Resolution 1. The Medical Care Study Committee was appointed with H. F. Falls, M.D., Ann Arbor, as Chairman and, as previously reported, recommended that an economist be included in the protective armamentarium of the State Society (see page 1048).

2. Resolution 5 re loan fund for new physicians. The Committee appointed to study this matter, headed by Wm. M. LeFevre, M.D., Muskegon, found (a) that the Michigan Foundation for Medical and Health Education, Inc., could not handle this additional loan area and, (b) the Michigan State Medical Society was not, especially this year, prepared to establish a loan fund from current revenues.

The Committee agreed to study the matter from two approaches: (1) expansion of existing programs to include new physicians, and (2) establishing an MSMS loan fund for this specific purpose. (The new AMA Loan Program for those in need may make the State program unnecessary.)

3. Resolution 6 re hospital emergency care was referred to a special committee of The Council headed by W. L. Brosius, M.D., Detroit. The Committee reviewed a report of the Wayne County Medical Society Physician-Hospital Committee which contains important and interesting information on the emergency care situation in Wayne County, as follows:*

(a) That the rate of utilization of these services is not too high and less than anticipated by Blue Cross when it expanded its out-patient hospital service in 1957. Prior to this time these services averaged 1 per cent of total income with average costs of $7.00 per case. In 1959 it was 2 per cent of total income and $8.56 per case.

(b) The hospitals operate emergency rooms as a service to the public and to the profession. To the hospital this community service is a financial burden.

(c) That although the cost to the patient who has Blue Cross (approximately six out of ten) for care in the hospital emergency room is less, the overall costs to the community are higher.

(d) That the highest quality of care can be provided by the family physician at his office. This is particularly true in medical emergencies which require history, diagnosis, and evaluation before medication is initiated. This committee stated in addition that in its opinion the responsibility and control for the hospital emergency room lies within the medical staff of each hospital. To avoid any misunderstanding, the committee recommended that hospitals make a reasonable effort to notify the family physician on admission of his patient to the emergency room and in all cases to send him a report about the treatment given.

The members of the Committee felt that there are similar problems throughout the State and recommended an MSMS-sponsored statewide survey of hospital emergency care by means of a questionnaire to all chiefs of staff of accredited hospitals in Michigan. This proposal was approved by The Council.

A communication from the Chairman of the Medical Advisory Committee to Michigan Hospital Service (Wm. S. Reveno, M.D., of Detroit) furnished this additional information:

"The Medical Advisory Committee of Michigan Hospital Service has in past years been confronted with several complaints dealing with alleged encroachment on private practice. Two of these have dealt specifically with the problem of physical therapy and several, notably one from a hospital in Flint, have been concerned with hospital emergency room care. In the latter instance the problem relates to the reimbursement of hospital for emergency room services which, in teaching hospitals maintaing intern and residency programs, includes the services of the intern and resident as a part of the hospital out-patient reimbursable expense. This available emergency service has allegedly resulted in many non-emergency cases going to the hospital emergency room for care that

*Published in the *Detroit Medical News*, May 16, 1960.

should properly be rendered in the doctor's office. To clarify the problem it is noteworthy that Michigan Hospital Service reimburses the hospital for the useage of its out-patient facilities and not for doctors' professional services. By policy, the cost of intern and resident training programs are included as part of Michigan Hospital Service reimbursable costs. Such training programs are operated at individual hospitals under the direction and professional supervision of the medical staff of the hospital. Michigan Hospital Service does not undertake to invade the province of the individual hospital medical staff or administrator to establish and control policy governing emergency room practices. It cannot undertake the emergency room policing of case intake and it should not be placed in the position of penalizing the hospital and its subscribers or the medical profession by depriving them of the beneficial aspects of ambulant nonprofessional services provided through hospitals. This conclusion was reached at a meeting of the Medical Advisory Committee on March 16, 1960.

"When Michigan Hospital Service undertook to reimburse hospitals for emergency room services it did so primarily to reduce hospital bed occupancy for minor situations. The matter of determining the eligibility of patients for this service was obviously left to be worked out by the individual hospital and its medical staff. So far, few hospital medical staffs have undertaken a thorough study of the problem and specific plans for screening admissions are practically non-existent.

"Why have the public demands on the hospital emergency room burgeoned? While it is likely that some may choose the hospital to save costs or because they believe insurance provides the service, the great majority seek aid because doctors are not available and their offices are not open twenty-four hours a day. When one undertakes to screen these patients it becomes necessary to define what is meant by emergency. The layman's idea of what constitutes an emergency is often far different from that of the physician and his decision to seek help starts generally at some weird hour during the night. Right or wrong he will seek aid for what he believes is an emergency and he cannot be denied that privilege, even though cooler judgment the next day dictates that no emergency existed. This, as you will recognize, is an exceedingly tricky problem and too rigid a set of rules can seriously damage the standing of hospital and doctor in the community.

"Thus it would seem that while Michigan Hospital Service has helped to make it easier to obtain emergency medical service by reimbursement to the hospital for established facilities such as physical plant and resident house staff, this constitutes only a small portion of the problem. Equally important are the demands of the layman, justifiable or not, and the availability of the practicing physician. The trend toward increased hospital emergency room clinic practice is therefore not being fostered by pre-payment plans alone. In order that such emergency care shall be rendered within the framework of the private practice of medicine it had best be supervised by the individual hospital medical staff and more pointedly by the individual practicing physician. The recommendation that Michigan Hospital Service discontinue the practice of "paying for routine clinic care" in hospital emergency rooms would not solve the problem since the public would continue as before to seek medical aid wherever it was available. Hospitals would continue to be stormed by the demands for services and would be compelled to render such services whether special departments were provided or not."

4. Resolution 7 re repeal of basic science law and enactment of a uniform healing arts act was referred to the Legal Affairs Committee which appointed a subcommittee to review the entire matter. An interim report of the subcommittee was presented to the Legal Affairs Committee on June 13 which included the results of a preliminary exploration of the subject with the deans of the two medical schools in Michigan and with the Judicial Council of the AMA. The Committee requested the subcommittee to continue its study of implementing Resolution No. 7 of 1960.

5. Resolution 9 re nurses training program: the action of the 1960 House of Delegates was directed to the various organizations in interest, as directed.

6. Resolution 16 re transfer of membership. The AMA recommended a solution might be reached on a regional basis, so correspondence was initiated with all the states in the Great Lakes region (Ohio, Indiana, Illinois, Wisconsin), all of whom expressed interest in the problem except Ohio. A meeting of representatives of the Great Lakes states was scheduled for New York, during the AMA Session, but in the meantime the introducer of the resolution (C. I. Owen, M.D., Detroit) asked that the matter be dropped. Further consultation on the subject among the Great Lakes states, through correspondence, is anticipated.

7. Resolution 17 re appointment of MSMS Historian. The Council was honored to receive acceptance from Wm. J. Stapleton, Jr., M.D., of Detroit as Historian.

8. Resolution 24 re employee recognition. The Council decided the appropriate time for this recognition was during the Christmas Holidays.

9. Resolution 25 re Presidents Program (this was previously reported—see item e, page 1045).

10. Resolution 39 re visual screening program was referred to the MSMS Child Welfare Committee which is implementing the directive of the 1960 House of Delegates.

11. Resolution 40 re insurance report forms. This information was disseminated through the MSMS Secretary's Letter.

12. Resolution 52 re adjustment of Michigan

Crippled Children Commission Fee Schedule. This was referred to the Legal Affairs Committee which reports elsewhere that encouraging progress was made in the 1961 Legislature toward revising the existing medical fee ceilings in the Crippled and Afflicted Children Acts (now, no more than $90 for any procedure or $200 for any one patient in any one year). The Committee feels that the ceilings, unchanged since 1948, may be raised to more realistic levels during the 1962 session. It is to be noted that the appropriation bill covering crippled and afflicted children services was amended to permit payment of physicians' bills for services rendered during the period July 1, 1960 to June 30, 1961 to said children when bills were rendered beyond 30 days after discharge of the patient; in other words, these tardy billings will now be paid by the State. In addition, legislative sentiment was developed in the 1961 session for increasing the maximum billing period under the Crippled and Afflicted Children Acts from 30 to 45 days.

Recommendation No. 7 on the subject of Uniform Fee Schedule for Governmental Welfare Agencies follows.

13. Resolution 53 re residency training programs: after a thorough discussion with the Secretary of the AMA Council on Medical Education and Hospitals, the introducer of this resolution (J. L. Livesay, M.D., of Flint) asked that this resolution be withdrawn as "no area of disagreement exists."

14. Resolution 54 re revised rules and order of business of the House of Delegates. This has been implemented by Speaker Lightbody and all information will be presented to Delegates in folders with the material on 8½"x11" printed or mimeographed sheets.

15. *Matters Referred to Michigan Medical Service*—All resolutions re the operation of Michigan Medical Service were referred to that Corporation on November 14, 1960 (resolutions No. 19, 41, 47, as well as the instruction that MMS revert to its original participating agreement). The Michigan State Medical Society turned over all material and records in connection with the MSMS Seal of Assurance Plan and M-75 participation agreements on December 5, 1960 and notified the MSMS membership through the Secretary's Letter that Michigan Medical Service is now handling all MMS participating agreements; and further that Michigan Medical Service will submit mediation matters to the component societies for referral to their own mediation or other appropriate committee. MMS reported its follow through on House of Delegates actions in a letter to The Council dated December 16, 1960.

An up-to-date report will be presented to the House of Delegates by Michigan Medical Service on September 25-26.

16. *Dedication of a Number of* The Journal *to Wilfrid Haughey, M.D.*—This was accomplished in the February, 1961 Number.

17. *Prevention of Highway Accidents.*—The Council wrote all auto manufacturers urging them to increase the use of safety factors in their products. Very fine and thoughtful explanatory replies were received from the auto officials, indicating their efforts in accident prevention and safety. MSMS expressed its great interest and offered cooperation which was accepted by the automobile manufacturers.

18. *Washington, D. C. Trip.*—As instructed by the House of Delegates, your representatives visited Michigan Legislators in Washington, D. C., April 30-May 3. This visit emphasized the continued need for a grass roots informational campaign and further that the startling change in concept of Social Security from indemnification to service, strongly invited to the Congressmen's attention, must be stressed to all MSMS members and to the public.

Recommendation No. 8 on this subject follows.

Recommendations

1. That The Council be authorized to arrange Councilor Conferences, prior to the Annual Session, to continue communication and share information with delegates, alternate delegates, and component society officers, as during the past four years.

2. That the House of Delegates approve the holding of an annual "General Meeting" of the State Society as part of the last meeting of the House of Delegates.

3. That the House of Delegates place on its record a high vote of commendation to the personnel of the Relative Value Scale Study Committee for three years' arduous labor in producing this scale in concert with all Sections and specialty groups of medicine in this State concerned with this important socio-economic matter.

4. That component societies stimulate congratulatory communications to magazine editors who present to their readers true facts on what Medicine is attempting to do for the benefit of the peoples' health; and conversely that they encourage letters of protest against unfavorable or slanted and untrue articles about Medicine that are published mainly to engender nation-wide controversy to increase sales for that particular issue of the magazine and not primarly for the public's good.

5. That the House of Delegates give serious consideration to the pressing need for the retaining by the Michigan State Medical Society of either a staff economist and/or the services of special consultant economists to evaluate socio-economic studies affecting medical practice, and that it instruct The Council in the procedure to be inaugurated including the financing of this new department activity.

6. That the House of Delegates encourage component societies and individual members to "accentuate the positive" in reminding the public that Medicine in the United States is the BEST

in the world and that any attempts to dilute its quality, through socialization, will mean less service to and poorer care for the people; and that the Kerr-Mills medical care for the aged program is working and working well for the people who need this program.

Further, that the House of Delegates request county societies to continue and to intensify their action program against political medicine for the aged; and that every MSMS member be urged to know and recognize the intense seriousness of the present threat to private medical practice and best medical care, and that they personally inform patients and other friends of this overt campaign for general socialism.

7. That component societies continue their work to revise their fee schedules for medical care of indigents so they are in line with the Uniform Fee Schedule for Governmental Welfare Agencies.

8. That The Council be authorized to send MSMS representatives to Washington, D. C., in 1962 on the occasion of the annual Michigan Day, as recommended for many years by the House of Delegates.

9. That the House of Delegates encourage component societies to discuss, at least every other year, the subject of malpractice as part of a necessary campaign of prevention; component societies will find their Councilor or the Chairman of the MSMS Committee on Malpractice qualified to speak on this subject.

H. J. Meier, M.D., *Chairman*
A. E. Schiller, M.D.
O. B. McGillicuddy, M.D.
W. A. Scott, M.D.
C. Allen Payne, M.D.
H. H. Hiscock, M.D.
John J. Coury, M.D.
E. S. Oldham, M.D.
R. V. Daugharty, M.D.
O. J. Johnson, M.D.
W. M. LeFevre, M.D.
J. R. Dehlin, M.D.
T. P. Wickliffe, M.D., *Vice Chairman*
B. M. Harris, M.D.
R. J. Mason, M.D.
W. C. C. Cole, Sr., M.D.
W. W. Babcock, M.D.
William Bromme, M.D.
J. J. Lightbody, M.D.
H. F. Falls, M.D.
K. H. Johnson, M.D., *President*
O. K. Engelke, M.D., *President-Elect*
D. Bruce Wiley, M.D., *Secretary*
W. A. Hyland, M.D., *Treasurer*
M. A. Darling, M.D., *Immediate Past President*

ANNUAL REPORT OF COMMITTEE ON BLOOD BANKS—1960-1961

There were no formal meetings of the Committee on Blood Banks during the year. There was, however, a scientific meeting held for one day by the Michigan Association of Blood Banks, which is co-sponsored by the Michigan State Medical Society and the Michigan Pathological Society. This meeting was held in November, 1960. Two workshops on blood banking techniques were presented during the year. All of these activities are aimed at improving the blood bank services in the state of Michigan.

R. L. Mainwaring, M.D., *Chairman*
F. R. Ellis, M.D.
W. G. Gamble, M.D.
L. W. Gardner, M.D.
D. L. Kessler, M.D.
R. E. Lininger, M.D.
E. E. Muirhead, M.D.
L. W. Walker, M.D.

ANNUAL REPORT OF COMMITTEE ON DIABETES—1960-1961

Your committee's activity mainly consisted of cooperation with the Michigan Diabetes Association in the campaign of diabetic detection.

Much emphasis was placed on the doctor's office as the most effective method of detection. Routine urinalysis on all patients and blood tests on those who have suspicious symptoms are expected of all physicians.

The committee also again advised county medical societies to include talks on the diagnosis and treatment of diabetes in their scientific meetings. The Postgraduate Medical Education Committee is again asked to include diabetes in their program. All county societies are to be informed of the Michigan Diabetes Association's Speakers Bureau and are urged to request speakers whenever possible.

Further efforts are to be made to get papers on diabetes included in the MCI and annual session programs of the state society. The matter of the increase in fetal mortality in pregnancies in diabetic women is to be referred to the Maternal Health Committee with the hope that that committee can help in obtaining a greater degree of diabetic control during pregnancy in order to reduce this rate.

William M. LeFevre, M.D. *Chairman*
T. H. Cobb, M.D.
J. A. Cowan, M.D.
P. J. Moore, M.D.
J. B. Rowe, M.D.
Bert Van Ark, M.D.
K. K. Vining, Jr., M.D.
H. L. Woodburne, M.D.

ANNUAL REPORT OF CANCER CONTROL COMMITTEE—1960-1961

The Cancer Control Committee of the Michigan State Medical Society held one meeting mainly for the purpose of reviewing the revised Bylaws of the Michigan Cancer Registry as recommended by the Michigan Cancer Coordinating Committee (at its January 12, 1961, meeting). The Cancer Control Committee approved the amended Bylaws of the Michigan Cancer Registry and recommended that The Council of the Michigan State Medical Society also approve same (which The Council did).

Scientific articles on cancer to appear in The Journal of the Michigan State Medical Society were allocated, on a bi-monthly basis, to various members of the Cancer Control Committee.

The Committee considered the lack of uniformity in reporting positive and negative smears and the need for informing physicians how to handle reports; it was felt that a uniform method of reporting should be developed on a national basis; the Committee authorized its Chairman to convey this information and suggestion to the Committee on Cytology of the American Cancer Society.

H. M. Nelson, M.D., *Chairman*
William Bromme, M.D.
E. I. Carr, M.D.
J. A. Cowan, M.D.
L. E. Holly, M.D.
J. W. Hubly, M.D.
W. A. Hyland, M.D.
C. Allen Payne, M.D.
H. M. Pollard, M.D.
Ralph Ten Have, M.D.
H. J. VandenBerg, Jr., M.D.

ANNUAL REPORT OF MEDICAL CARE STUDY COMMITTEE—1960-1961

There have been three meetings of this Committee since its establishment: May 3, 1961, May 24, 1961, and June 18, 1961.

The specific recommendations of this Committee have been submitted to the House of Delegates in a more detailed report. They include in particular:

(1) Establishment of a standing MSMS Committee on Medical, Social, and Economic Trends.

(2) Establishment of a MSMS Department of Socio-Economics.

(3) Employment by MSMS of an Economist.

(4) That this Economist be located in the Detroit area near major research facilities.

(5) MSMS provide $30,000-$35,000 per year for establishment, implementation of functions, employees, etc., of this Department of Socio-Economics.

(6) Establishment of Socio-Economic committees by all component County Medical Societies and other medical organizations.

(7) Urge House of Delegates Reference Committee on Ways & Means to recommend financing this program.

(8) Urge retaining services of consultants, on per-diem basis, of established independent economists to advise on emergency, particular questions or problems.

H. F. Falls, M.D., *Chairman*
D. L. Kessler, M.D.
L. R. Leader, M.D.
O. B. McGillicuddy, M.D.
J. W. Rice, M.D.
G. W. Slagle, M.D.
D. N. Sweeny, Jr., M.D.

ANNUAL REPORT OF THE PUBLIC RELATIONS COMMITTEE—1960-1961

During the year just past, this Committee has strived to increase its production. The result has been fewer projects but greater extension of service to establish communication media and through ancillary, auxiliary and related vocational and professional organizations.

In addition to the work noted in the report of The Council, and supplementing the work of many scientific and socio-economic committees, we have carried out a program designed to so inform and persuade the public that it will continue to have confidence in the practicing doctor of medicine, his organizations and his philosophies.

Television and Radio: Additional "family doctor" television shows to those of last year were presented supplemented by appearances over established programs or on specially allocated periods. Cooperation was given to the Michigan Association of the Professions—Michigan Health Council TV program "Decision—The Moment of Truth," a program built to explain why professional people do-what-they-do-in-the-way-that-they-do-it and how to make best use of professional people. Several radio programs were originated by MSMS and participation by M.D.'s in these programs were outstanding. Continued support was given the U. of M. health series broadcast in tape over local radio stations.

Intra-Professional Liaison: Visits to county medical societies, the Upper Peninsula Medical Society and sundry specialty groups maintained intra-professional liaison. All requests for services by county medical societies or individual members were gladly received and carried out.

Motion Pictures: The documentary film on the new MSMS Headquarters was completed. This film will be used as part of the President's Program, and to acquaint the membership and the public with the new building and the expanded services of MSMS. Several films prepared by the AMA and other recognizably authoritative organizations were purchased and/or distributed.

Michigan Association of the Professions: This organization has grown to a membership of 3,616 and has effectuated a brilliant program of service in the fields of: 1. Education, 2. Public Relations, 3. Legislation, and 4. Business Services. Of particular advantage to the medical profession were:

(a) The Congress of the Professions—Detroit, February 22-23-24, which held hearings on the subjects noted above and presented among other outstanding speakers, Thomas A. Francis, Jr., M.D., Department of Epidemiology, School of Public Health, University of Michigan, Ernest B. Howard, M.D., Assistant General Manager of the American Medical Association, The Honorable John W. Byrnes, United States Congressman of Wisconsin, and Charles R. Sligh, Jr., Executive Vice President of the National Association of Manufacturers.

(b) Day-long meetings to recruit students such as that held at Saginaw, where students from a large area were interviewed by 7 deans of graduate schools, among them Dean Gordon H. Scott, Ph.D., College of Medicine, Wayne State University. Another conference with guidance counselors was held at Alma College with such men in at-

tendance as Lyman Smith, Director of AMA Scholarship program, Nicholas Mizeres, M.D., College of Medicine, Wayne State University and representatives of several professions as well as the guidance counselors.

(c) Legislative support of the Keogh Bill and opposition to the Forand Bill by letter.

(d) The implementation of Group Term Life, Major Medical Insurance and disability insurance programs, plus other business services such as the "new office" furnishing and equipping program.

"Decision—The Momenth of Truth." The taping and telecasting of a weekly series of TV shows over WJBK-TV Detroit and other channels (soon to be seen over Channel 56 Detroit and Channel 10 Lansing) on various medical and health subjects in cooperation with MAP and the Michigan Health Council. Many doctors cooperated on this series of programs.

Pamphlets: Distribution of AMA pamphlets was emphasized this year in view of the excellence of these publications. Schools, school libraries, doctors' offices, etc., served as outlets for these. In addition, the MSMS "Emergency Medical Card" and the pamphlet "Your Family Health Record" were distributed in the number of several thousand and a special display poster-pamphlet and insert-card was prepared.

Public Relations Conference: The County Secretaries-Public Relations Seminar was held in January. An excellent attendance complemented an outstanding roster of speakers.

Mass Media: By means of press releases to all Michigan newspapers, radio and TV stations, reports of current work of MSMS was carried to the general public. Also special stories were released to home-town papers of Doctors who received special honors. The work of the staff with the newspapers is a never-ending task highlighted by special work under the direction of the Press Committee at the Annual Session and the M.C.I.

Speakers Program: For the fifteenth consecutive year, a group of M.D. speakers appeared before service clubs of Detroit and Grand Rapids in connection with Annual Session and M.C.I. weeks. Throughout the year, the medical profession served the schools, colleges, clubs, ancillary groups and business organizations with a steady flow of speakers on an unusually broad variety of subjects—uppermost this year, were talks on the problems of the aged, including the Michigan White House Conference on Aging and the National White House Conference on Aging.

Publications: Many legislative and other special bulletins were issued during the past year. Aid was given The Auxilium, meeting announcements and JMSMS articles. The new publication, *Medical Economic Currents*, was published containing capsulated and charted facts of major interest. This was sent to 1,000 MSMS members who have state and county responsibilities which place them in the position of developing policy and expressing medicine's position to the public. This publication also provided opportunity for the reprinting of these charts in county society bulletins. The new Medical Career Guide was prepared by MSMS and published by the Michigan Employment Security Commission. The special sub-committee in charge of this project was headed by J. M. Sheldon, M.D. In addition, a revision and reprinting of "Planning Your Career," the publication about medical associates' careers was accomplished.

PR Library: This growing repository of working materials continues to increase in value and usage. Adequate accommodations have been made available and it is anticipated that next year will see a vastly increased service emanating from this valuable facility.

Civic Affairs: Increased interest in civic affairs has been evidenced by county societies during the past year. Delegations of doctors to Lansing and Washington, D. C., participating in Aging Conferences, Regional Health Conferences, political parties, local "Homearamas," etc., have indicated an increasing interest by the profession in civic duty.

Michigan Health Council: Directional and cooperative services in connection with the Michigan Health Council, including the 13th Annual Michigan Rural Health Conference, the 3rd Annual Michigan Health Careers State Conference and the 1st Michigan Conference of the Joint Council to Improve the Health Care of the Aged, and the Michigan Health Council State Health Conference was held in Flint, May 23-24. This proved to be one of the finest medical conferences of a socio-economic nature in the state this year, but more attendance by doctors of medicine is urged in the future.

President's Program: The President's Program, to be reviewed elsewhere, is getting under way and vast possibilities for outstanding public relations gains are inherent in it.

Comment: Try as the profession will, the concerted efforts of its powerful enemies (enemies not of scientific medicine but of the profession's concept of the best way to practice medicine) are making inroads in public thinking. This Committee feels duty-bound to urge increased activity (and financial support) in the future, both on the part of the individual doctor and of organized medicine.

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E. S. Oldham, M.D., *Advisor*
A. E. Schiller, M.D., *Advisor*
T. P. Wickliffe, M.D., *Advisor*

ANNUAL REPORT OF COMMITTEE TO STUDY PROBLEM OF MALPRACTICE 1960-1961

No matters were referred to the House of Delegates Committee to Study Problem of Malpractice during the 1960-1961 Society year and, therefore, no meetings were scheduled. However, this Committee wishes to reiterate the statement urging component medical societies to have regular meetings to discuss the problem of malpractice and the avoidance of malpractice suits.

Material for such discussions and/or talks is available to the component medical societies at the office of the Committee Chairman, William M. LeFevre, M.D., 315 Clay Avenue, Muskegon, Michigan.

The Chairman and members respectfully recommend to the House of Delegates that this Committee be retained during 1961-1962.

William M. LeFevre, M.D., *Chairman*
E. W. Hall, M.D.
F. B. MacMillan, M.D.
Wm. J. Stapleton, M.D.
A. J. Vorwald, M.D.
F. G. Buesser, LL.B., *Ex Officio*
Lester P. Dodd, LL.B., *Ex Officio*

ANNUAL REPORT OF COMMITTEE TO REVIEW CONSTITUTION AND BYLAWS 1960-1961

The Committee met on May 21 and twice subsequently during the year and concluded a complete examination of the Constitution and Bylaws item by item.

Our report will reach the Delegates well before the Annual Session in the form of a copy of the new and the old Constitution and Bylaws in order that a complete examination may be conducted.

In accordance with the recommendation of the 1960 Committee, the present work constitutes a complete revision with such corrective changes in language as were deemed necessary and a shifting of chapters or sections has been done in order to consolidate items bearing on the same subject.

The result is a more pleasing and easily usable document which will be completely indexed for quick reference. The unusual detail and effort involved is the work of our Legal Counsel, Lester P. Dodd, whose tremendous contribution is gratefully acknowledged.

L. J. Bailey, M.D., *Chairman*
R. R. Cooper, M.D.
A. B. Gwinn, M.D.
H. J. Meier, M.D.
F. P. Rhoades, M.D.
J. A. Witter, M.D.
L. P. Dodd, LL.B., *Advisor*

ANNUAL REPORT OF MEDIATION COMMITTEE—1960-1961

No matters were brought to the attention of this Committee during the past year, so it was unnecessary to call the Committee into session.

L. R. Leader, M.D., *Chairman*
D. R. Boyd, M.D.
E. B. Johnson, M.D.
R. P. Lytle, M.D.
G. B. Saltonstall, M.D.
E. F. Sladek, M.D.
R. W. Teed, M.D.

ANNUAL REPORT OF THE LEGAL AFFAIRS COMMITTEE, 1960-1961

The Michigan Legislature spent seventy-eight days in actual session during 1961 and considered nearly 1,100 proposed laws and over 240 resolutions. Close to one hundred of these had direct medical implications.

The session was particularly marked by the persistent and repeated efforts of the chiropractic group to expand their privilege and practice. In general, veteran observers are unanimously agreed that the entire 1961 session was the most hectic and arduous in memory.

During the session eight "Legislative Reports" were mailed to CMS officers, three of which went to all MSMS members.

As the session progressed the Legal Affairs Committee considered proposed legislation concerning: mechanical procedures regarding eligibility under the Crippled and Afflicted Children Acts, county health department regulations, various health appropriation measures, workmen's and unemployment compensation amendments, a suggested Health Advisory Board, amendments to the Dental Practice Act and the proposed establishment of a State Scholarship Committee.

The Legal Affairs Committee also reviewed all

proposed appointments by the Governor to health-connected State boards, agencies and commissions, and embarked on a study of the implications of Single Medical Practice Act legislation. Exploration of the possibility of repeal of the Basic Science Act with all interested agencies and involved parties led to the committee conclusion that it would be unwise to proceed in this direction at this time. The committee recognizes the possibility that some recommendation regarding a single licensing agency might eminate from the 1961 Constitutional Convention, in which case the matter would go before the people for acceptance or rejection.

The final status of specific key legislation during this session follows:

Medical Aid to the Aged—Passed, without recognizing chiropractic services as medical services; liberalized by permitting income of married couples up to $2,500 (formerly was $2,000), and adding home nursing care and up to 90 days in any one year of nursing home care following hospitalization for acute illness.

Chiropractic Licensure—bill to permit treatment by chiropractors of "any human ailment or disease" was defeated.

Physical Therapists—bill to license defeated; contained amendment to legalize all "present practices" of chiropractors.

Hospital Licensure—this proposal did not pass.

Dispensing Opticians—a proposal for a new licensure law did not pass.

Optometrists—a bill confirming the present practice of contact lens fitting as a part of the practice of optometry passed, although opposed by Michigan Ophthalmologists.

Cancer Quackery—a proposal to control did not pass, pending study of newly enacted similar legislation in three other states.

Drugs—a proposal that all prescriptions be written on forms provided by the State Board of Pharmacy did not pass; a proposal which would have required all physicians to obtain a special dangerous drug license from the State Board of Pharmacy to handle certain drugs did not pass.

Crippled and Afflicted Children Acts—appropriation bill amended to permit payment of physicians' bills for services rendered, during the period July 1, 1960, to June 30, 1961, to crippled and afflicted children when such bills were rendered in excess of 30 days after discharge of the patient.

Psychologists—proposal to reduce basic requirements for licensure did not pass.

Drunk Driver Testing—proposal to improve the law passed in 1960 did not pass both houses, but did pass State Senate.

Ambulances—proposal to provide minimum standards for ambulance operation did not pass.

Legislative sentiment was developed for (1) increasing the maximum billing period under the Crippled and Afflicted Children Acts from 30 days to 45 days and (2) for establishing minimum standards for ambulance operation. Both goals may be reached during the 1962 session.

Encouraging progress has also been made toward raising the existing medical fee ceilings in the Crippled and Afflicted Children Acts (no more than $90 for any one procedure or $200 for any one patient in any one year). These ceilings have been unchanged since 1948, and may be raised to more realistic levels during the 1962 session.

The following Legislative Interim Study Committees were established by the Michigan Legislature: (1) to investigate the Blue Plans, (2) to investigate the optical sciences, and (3) to investigate the Crippled and Afflicted Children Acts.

On the Washington, D. C., scene, the concerted drive to establish the "service principle" of medical care, as opposed to cash benefits, under social security has dominated MSMS interest. MSMS representatives including the Legal Affairs Committee Chairman attended a special medical legislative conference on this subject in Chicago in mid-March and the Chairman reported on this meeting to the special session of the House of Delegates held in East Lansing in mid-April. An MSMS delegation went to Washington, D. C., in early May to discuss pending social security legislation with all Michigan members of Congress.

During this extremely active year for the Committee, its members are deeply grateful for the splendid cooperation of all MSMS members whenever their assistance was requested in calling facts to the attention of State and National lawmakers. It was largely through the instant and effective response of MSMS members that Michigan legislators were well advised on critical proposals in Lansing, and that Michigan members of the Congress have been apprised of the continuing desire of the medical profession to maintain for the United States the finest quality of health care in the world today. The Committee sincerely thanks each and every member.

L. A. Drolett, M.D., *Chairman*
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H. A. Towsley, M.D.
B. C. Wildgen, M.D.
Mr. Lester P. Dodd, *Advisor*

ANNUAL REPORT OF THE CHILD WELFARE COMMITTEE 1960-1961

The Child Welfare Committee held two meetings during the past year, December 8, 1960, and June 14, 1961. Included in their discussions were

reports from the various subcommittees which had also met during the past year.

The Committee received a report that some progress was being made with Adoption Agencies, although proposed revisions in the law did not provide all that would be desired with regard to adoption of children. The Committee was further advised that there were 6,000 adoptions, per year, in Michigan, with slightly over half adopted by stepfathers, about 1,500 being adopted through official agencies and another 1,500 being placed direct by the mother, without legal approval.

The Committee was advised concerning the training and supervision of Audiometric Screening Technicians provided by the Michigan Department of Health. It should be noted that children found with hearing loss are examined by Otologists and referred to their own physicians for treatment. Over 70 per cent have returned to normal, or greatly improved hearing. The Child Welfare Committee has requested an issue of JMSMS in 1962 and propose to develop articles concerning Otolaryngology, Psychiatry, Ophthalmology and other fields involved with child health.

The Subcommittee on Ophthalmology had discussed the need for pre-school examination materials for both sight and hearing, and had met unofficially with representatives of the Michigan Optometric Association.

The Committee participated in the preparation of the "Michigan School Health Record," CA 60-C form, which has been approved by the State Department of Public Instruction and the Michigan Department of Health for use in schools throughout the state. The Committee is currently working on the preparation of a simple form for physicians to use in transmitting to schools, following examination of children in their offices, pertinent information for the CA 60-C record.

The Committee is working with the Michigan Department of Health toward the development of rules and regulations for Pediatric Departments of General Hospitals, to be available if a General Hospital Licensing Law is passed by the Michigan Legislature.

The Committee is much concerned with Youth Fitness Programs and felt a serious need for leadership by members of the medical profession.

A resolution was passed, as follows:

Whereas, the Health of the youth of the nation is of primary importance to national development and security, and

Whereas, the Doctors of Osteopathy are working in some areas in youth fitness and development, and

Whereas, there is available personnel to advise and counsel from the State Health Department, therefore be it

RESOLVED, That the Michigan State Medical Society, as part of the Presidents Program, contact every county medical society regarding the formation of local Youth Fitness Committees and urge these committees to meet with Parent Teacher Associations, Athletic Directors, and Coaches to develop a continuing program of youth fitness on a local level, and be it further

RESOLVED, That to implement this program and a further step in the Presidents Program, this resolution be presented to the House of Delegates of the Michigan State Medical Society in September 1961.

R. H. Trimby, M.D., *Chairman*
J. C. Montgomery, M.D., *Vice Chairman*
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M. H. Pike, M.D.
H. A. Towsley, M.D.
A. L. Tuuri, M.D.
E. H. Watson, M.D.

Federal Request

Commissioner of Food and Drugs George P. Larrick has called on the pharmaceutical industry, the medical profession, and retail druggists to intensify their efforts to stamp out abuses in the repacking of physicians' samples.

At the same time, the Commissioner directed Food and Drug Administration inspectors throughout the country to increase their activities in this field.

The action came in the wake of discovery of an additional mix-up in repackaged physicians' samples in the possession of a retail pharmacy in Kansas City, Missouri.

A total of 15 seizures of physicians' sample drugs that were being held for sale has been instituted by FDA in the last two weeks.

The Commissioner recommended four steps including a reduction in the distribution of physicians' samples of drugs to that quantity which may reasonably be used by physicians in their practice.

Technical Exhibitors

(Alphabetic List)

Abbott Laboratories **Booth No. 305**
North Chicago, Ill.

Abbott Laboratories invites you to visit our exhibit. Our representatives will be happy to answer any questions you may have concerning our leading products and new developments.

A. S. Aloe Company **Booth No. 118**
St. Louis, Mo.

A. S. Aloe Division of Brunswick Corp. proudly exhibits its new 2nd Century Physicians examining room furniture. New concepts in function, construction and advanced materials.
Shown, too, is a group of new items developed for and by doctors to simplify and speed office techniques of diagnosis and treatment.

American Sterilizer Company **Booth Nos. 510-512**
Erie, Pa.

Ames Company, Inc. **Booth No. 106**
Elkhart, Ind.

The many urine diagnostic specialty products of Ames Company will be on display. You are cordially invited to stop at the booth for a demonstration. The application of these tests to office procedure can save you time and money. LET US DEMONSTRATE!
Therapeutic products including DECHOLIN/Belladonna will be presented.

Armour Pharmaceutical Company **Booth No. 206**
Kankakee, Ill.

The Armour Pharmaceutical Company exhibit will feature Chymoral, a new systemic anti-inflammatory enzyme tablet which reduces inflammation, swelling and pain; Chymar Aqueous, the parenteral systemic anti-inflammatory enzyme; and Chymar Ointment, the topical form.

Astra Pharmaceutical Products **Booth No. 314**
Worcester, Mass.

Descriptive literature pertaining to preparations of XYLOCAINE® HYDROCHLORIDE (ASTRA) for infiltration, regional block, peridural, spinal, and topical anesthesia, XYLOCAINE OINTMENT, XYLOCAINE JELLY, and XYLOCAINE VISCOUS for topical application, as well as ASTRAFER® I.V. for iron deficiency states, will be available at the ASTRA booth presided over by Edward W. Friedel.

Audio-Digest Foundation **Booth No. P-11**
Glendale, Calif.

Audio-Digest Foundation (a non-profit subsidiary of the California Medical Association) gives the busy physician a time-saving tour through the best of some 600 current medical journals, plus the highlights of scores of national meetings. Time-proven, but still unique—these medical tape-recorded services are now offered in six series—General Practice (issued weekly and bi-weekly), and Pediatrics, Internal Medicine, Surgery, Obstetrics and Gynecology, Anesthesiology (all issued semi-monthly). The one-hour long tapes are selected and reviewed by a professional Board of Editors. Digest subscribers listen in their car, home or office. The Foundation also offers medical lectures by nationally-recognized authorities.

Baker Laboratories, Inc. **Booth No. 416**
Cleveland, Ohio

You are invited to visit our booth where Baker's Modified Milk and Varamel, two successful products for infant feeding, are on display.
Baker representatives will be glad to discuss the benefits of Baker Milk products which provide all the normal dietary requirements plus a reserve for stress situations.

Barry Laboratories, Inc. **Booth No. 104**
Detroit, Mich.

YOU—will want the latest information on—
BARTHRO—The non-steroid, non-toxic Enzyme treatment for Arthritis.
MERPHENE—The most effective germicide non-injurious to mucous linings. Will kill antibiotic resistant Staphylococcus aureus in less than 30 seconds and clostridium tetani in less than 5 minutes.
ALLERGY—A growing problem of the medical profession.

Baxter Laboratories, Inc. **Booth No. P-19**
Morton Grove, Ill.

Baxter Laboratories, Inc., cordially invites you to view its latest developments in parenteral fluid therapy.
The Travenol Division features the regional perfusion oxygenator, PERFUSO-PAC™, which serves as a small "heart-lung" for the portion of the body undergoing treatment for certain cancers, and permits administration of huge doses of cancer-fighting drugs previously not used in such quantity because of possible damage to vital organs, and COZYME® for the physiologic correction and prevention of intestinal atony, abdominal distention, retention of flatus and feces and paralytic ileus.

Borcherdt Company **Booth No. 110**
Chicago, Ill.

MALTSUPEX® (Malt Soup Extract), Liquid and Powder. Laxative modifier of milk for constipated babies. Also useful for geriatric constipation and pruritus ani.
UROLITIA®: For chronic urinary tract infections in older patients. Quickly relieves burning urination. Especially useful for use over a long period of time.
FERROMALT® TABLETS: Non-constipating Ferrous Sulfate Tablets. Good clinical response without usual side effects of oral iron. Ferromalt Tablets are inexpensive and well tolerated.
Stop in for recently published papers and samples.

The Borden Company **Booth No. 508**
New York, N. Y.

Extending the "Metha" principle to a wider area of topical dermatological usefulness, *new* Methatar, new new Methaphor and new Methaseptic are being introduced at the Borden exhibit. A concise guide to treatment of skin disorders with "Metha" topicals is available
Also on display are the well established infant nutritionals, Bremil & Mull-Soy.

Bristol Laboratories **Booth No. 215**
New York, N. Y.

Continuing its program of developing antibiotics for almost every antibacterial infection, Bristol Laboratories' exhibit will feature one of its synthetic penicil-

lins. This display will communicate the significant advantages of this Bristol Antibiotic by a visual description of its *in vitro* and *in vivo* activity. Representatives will be available to discuss the details of synthetic penicillins.

Brooks Appliance Company **Booth No. 313**
Chicago, Ill.

The Brooks Appliance Company will exhibit and describe in detail the technique of applying the combination pressure bandages. The moist medicated primer Bandage plus the Dalzoflex Elastic Adhesive Bandage which are used in treating leg ulcers and phlebitis.
As distributors of Anatomical Supports, our representatives will be in attendance to answer questions and explain in detail our Sacral, Sacral-Lumbar and Dorsal-Lumbar supports. Also, the Dr. Hackett "nationally approved" "C" Sacral belt, Flexion and Extension Cervical Collar, Brooks Cervical Traction Outfit, Elastic Stockings, Nulast Elastic Crepe Bandages and Surgical Instruments will also be displayed.

Burroughs Wellcome & Company, Inc. **Booth No. 202**
Tuckahoe, N. Y.

You are cordially invited to visit Burroughs Wellcome & Co. (U.S.A.) Inc., Booth 202, for the latest information on our products, and the newest developments from the extensive research facilities of Burroughs Wellcome & Co.
Of particular interest at this meeting will be our new topical and ophthalmic antibiotic products, as well as our 'Actifed-C' Expectorant. Our informed staff welcomes this opportunity to show you these new products.

Cambridge Instrument Company, Inc. **Booth No. 514**
New York, N. Y.

The Cambridge "Versa-Scribe"—the Versatile Portable Electrocardiograph; and the Cambridge "Simpli-Scribe" Model Direct-Writing Portable Electrocardiograph will be displayed at this booth. Also other important Cambridge instruments, including the Audio-Visual Heart Sound Recorder, Operating Room Cardioscope, Educational Cardioscope, Multi-Channel Physiological Recorder, Electrokymograph, Plethysmograph, pH Meters, and Pulmonary Function Tester. The Cambridge Engineers in attendance will be glad to give you complete information on these instruments.

Cameron Surgical Instruments Co. **Booth No. 203**
Chicago, Ill.

Cameron Surgical Instruments Company will display its new Major Electrosurgical Unit for hospital use, as well as those for modern office surgery. Also showing Suction Coagulation Electrodes, Snares, Biopsy Forceps, electrically illuminated Ano-Procto-Sigmoidoscopic equipment (distal and proximal), Vaginal Speculae, Otoscope, Mouth Gag, Transilluminators, Gastroscopes, Headlites, Binocular Loupes, Luxo Lamps, etc. We would like the opportunity of demonstrating to you.

Carnation Company **Booth No. 116**
Los Angeles, Calif.

Carnation Company cordially invites you to visit Booth No. 116, where Medical Representatives will be pleased to welcome members and guests of the Michigan State Medical Society.
Recent literature and information regarding Carnation Evaporated, Carnation Instant Non-Fat, and Carnalac are available.
Any Question pertaining to our physician-researched material for use in your practice or hospital will be cheerfully discussed.

Chemico Laboratories, Inc. **Booth No. 213**
Miami, Fla.

Chemico Laboratories, Inc., will exhibit Reticulose, a lipoprotein-nucleic acid complex, produced in an injectable form and reported effective in the therapeutic management of various virus infections, i.e., Herpetic diseases, Infectious Hepatitis, Encephalitis, Vaccinia, Influenza, Infectious Mononucleosis, with clinical improvement objectively and subjectively anticipated in 24 to 36 hours.

Chicago Pharmacal Company **Booth No. 316**
Chicago, Ill.

URISED: Clinically proven tablet for both comfortable sedation and thorough antisepsis in genitourinary affections.
MYOSED: A brand-new styramate skeletal muscle relaxant combined with two well-tolerated analgesics, salicylamide and phenacetin in tablet form, for quick and lasting relief of pain in strains, sprains, osteoarthritis and bursitis without side effects.

Ciba Pharmaceutical Products, Inc. **Booth No. 319**
Summit, N. J.

FORHISTAL® is a new, low-dosage antiallergic and antipruritic agent. Clinically, FORHISTAL has proved highly effective in a wide range of allergic and pruritic disorders. It is well tolerated by patients of all ages. FORHISTAL is available in 4 forms of issue: Lontabs®, Tablets, Syrup and Pediatric Drops.

Coca-Cola Company **Booth Nos. P-9, P-10**
Atlanta, Ga.

Ice-cold Coca-Cola served through the courtesy and cooperation of the La Salle Coca-Cola Bottling Company, Grand Rapids, Michigan and The Coca-Cola Company.

Desitin Chemical Company **Booth No. 505**
Providence, R. I.

DESITIN OINTMENT: For treatment of burns, ulcers, diaper rash, abrasions, etc.
DESITIN POWDER: Relieves chafing, sunburn, diaper rash, etc.
DESITIN SUPPOSITORIES and RECTAL OINTMENT: Relieve pain and itching in uncomplicated hemorrhoids, fissures.
DESITIN BABY LOTION: Protective, antiseptic.
DESITIN ACNE CREAM: A non-staining, flesh-tinted "Medicream" for the treatment of Acne Vulgaris.
DESITIN COSMETIC & NURSERY SOAP: Supermild.
DESITIN SUPPOSITORIES with HYDROCORTISONE: Prompt response to inflammatory conditions in proctitis, severe pruritus, edema.
DESITIN OINTMENT with HYDROCORTISONE: Provides hydrocortisone 1% (as the Alcohol) added to the well-known Desitin formula of Norwegian cod liver oil.
DESITIN HYDROCORTISONE CREAM: Non-staining, washable hydrophilic base with sol. al. acetate. An elegant cosmetic preparation with HC 1%.
DESITIN C OR-D-TAR CREAM: Desitin Cor-D-Tar Cream—non-staining hydrophilic base with a special solution coal tar 3% and non-staining diodohydroxyquin 2%. For bacterial-fungal-infectious eczematous discomfort.

Dictaphone Corporation **Booth No. 111**
Grand Rapids, Mich.

Displayed are the latest in our product line of Transisterized Thought Recording Instruments. A "Who's Who" of Hospitals, Clinics, Sanatoria, and Professional Men in all specialized fields of medicine, substantiate the time-saving values of Dictaphone products. We welcome you to visit our booth and become better acquainted with our total product line.

Dietene Company **Booth No. 112**
Minneapolis, Minn.

Have you tasted Meritene? Meritene is the good-tasting *Protein*-Vitamin-Mineral Food Supplement prescribed to provide concentrated nutrition for patients with poor appetite or tolerance for ordinary food. Visit our booth and let us serve you a cool, refreshing Meritene Nourishment.

While there, review also our Dietene Reducing Plan, designed to get better cooperation from overweight patients. The Dietene Plan provides optimum nutrition and maximum satiety without the use of drugs.

Meritene and Dietene are advertised only to the Medical Profession.

Doho Chemical Corporation **Booth No. 414**
New York, N. Y.

DOHO CHEMICAL CORPORATION IS PLEASED TO EXHIBIT:

AURALGAN Ear medication for relief of pain in Otitis Media; also removal of Cerumen;

RHINALGAN Nasal decongestant free from systemic or circulatory effect. Safe for infants—aged.

OTOSMOSAN Non-Toxic fungicide-bactericide (gram negative-gram positive) for suppurative and aural dermatomycotic ears;

LARYLGAN Soothing throat spray and gargle for infectious and noninfectious sore throat involvements.

BIOTOSMOSAN HC The solution to the "Problem Ear." Antimicrobial, Anti-inflammatory, De-inflammatory, Anti-allergic, Antipruritic

Dome Chemicals, Inc. **Booth No. 415**
New York, N. Y.

Eaton Laboratories, Inc. **Booth No. P-15**
Division of The Norwich Pharmacal Co.
Norwich, N. Y.

FURACIN TOPICAL CREAM—new convenient form and Rx size of Furacin® (nitrofurazone). For treatment of infected surface areas. For treatment and prevention of infections associated with irradiation or surgical removal of external malignant growths. Furacin Topical Cream is particularly suitable for use in postoperative anal, rectal or pilonidal cyst wounds. It facilitates healing, minimizes drainage and malodor. Our representatives will supply you with complete information.

Encyclopedia Americana **Booth No. 309**
Grand Rapids, Mich.

Encyclopedia Americana most cordially invites you to inspect their newly revised 1961 edition featuring *Min-Max* the self-tutoring machine described by *Time* magazine as follows: "The first real innovation in teaching since the invention of movable type during the Fifteenth Century." We also have a souvenir for you without obligation.

Encyclopaedia Britannica **Booth No. 210**
Detroit, Mich.

WILL SHOW 1961 EDITION OF ENCYCLOPAEDIA BRITANNICA SENIOR IN OUR BEAUTIFUL WHITE IMPERIAL BINDING. ALSO ACCESSORIES. BE SURE TO ASK ABOUT OUR EXHIBIT SPECIAL. REPRESENTATIVES ON DUTY: T. ELLIOTT AND P. JOHNSON.

Ferndale Surgical, Inc. **Booth No. 101**
Division of J. F. Hartz Company
Ferndale, Mich.

Geigy Chemical Corporation **Booth No. P-14**
Yonkers, N. Y.

Geigy cordially invites Members and Guests of the Association to visit its exhibit. The exhibit features important new therapeutic developments in the management of inflammation, as well as current concepts in the control of hypertension and edema; depression; obesity, and other disorders, which may be discussed with physicians and representatives in attendance.

Gerber Products Company **Booth No. 216**
Fremont, Mich.

NEW! Gerber MODILAC . . . A complete formula for infants. Gently processed to conserve nutritional values, it has true milk color and flavor. Modilac *is* milk adapted to the infant's physiologic requirements by the addition of a selected carbohydrate, replacement of butterfat with corn oil and supplementation with needed vitamins. Ask for complete information.

Great Books of the Western World **Booth No. 511**
Chicago, Ill.

The SYNTOPICON is a huge two-volume 2,428 page "Dictionary of Ideas" compiled under the direction of Mortimer Adler by 100 eminent scholars over an eight year period at a cost of millions of dollars. By means of 163,000 references to 3,000 topics, it instantly guides you directly to each of the Great Authors who have discussed your subject . . . immediately refers you to specific volumes, pages and passages in the GREAT BOOKS where your idea or problem is discussed.

Now—through the development of an amazing new literary invention the SYNTOPICON—you can read and profit from the GREAT BOOKS even if you can spare only minutes a day.

Health Insurance Council **Booth No. 107**
New York, N. Y.

Our exhibit is designed to provide general information on health insurance as underwritten by insurance companies. In addition, it also makes available information on uniform claim forms for use by doctors and hospitals in support of health insurance claims.

H. J. Heinz Company **Booth No. 208**
Pittsburgh, Pa.

Become acquainted with Heinz Baby Foods—over 115 varieties—a complete line of Instant Cereals; Baby Juices with vitamin C; 100% Meats; High Meat Dinners; Vegetables; Vegetable-Meat combinations; Fruits; Puddings and Desserts. Newest of these foods are Apple-Cherry Juice; Junior Peaches with vitamin C added and Strained Creamed Corn.

At the exhibit you will see books on infant feeding and prenatal care and nutritional literature. Pads listing our entire Baby Foods line with ingredients are also available.

Hoekstra Shoe Company **Booth No. 205**
Grand Rapids, Mich.

We will be exhibiting all forms of corrective and orthopedic shoes for men, women and children. Also our display will consist of the different types of construction put into these shoes.

Holland-Rantos Company, Inc. **Booth No. 109**
New York, N. Y.

The H-R exhibit will feature:

. . . Antimycotic (non-messy) *HYVA Gentian Violet Vaginal Tablets;*

. . . Trichomonicidal/fungicidal/bactericidal *NYLMERATE Jelly and Solution Concentrate* for trichomonas and vaginitis and mixed infections;

. . . Medicated *HOLLANDEX Ointment* with Silicones and Natural Vitamins A & D;

. . . Special *KOROMEX* [A] for use when "jelly-alone" is advised for conception control; contouring

KORO-FLEX Diaphragms (facilitate correct placement) and standard *KOROMEX Jelly, Cream, Diaphragms and Sets.*

G. A. Ingram Company **Booth Nos. 302-304**
Detroit, Mich.

The G. A. Ingram Company will have in its booth, for the doctors to stop and see, not only the newest diagnostic and surgical instruments and equipment, but also the latest items to improve procedures and techniques in the doctors' offices.

Johnson & Johnson **Booth No. 320**
New Brunswick, N. J.

Johnson & Johnson will display the latest improvements in surgical dressings, as developed by the Johnson & Johnson Research Laboratories. Of special interest is SURGICEL Absorbable Hemostat, a major advance in the control of hemorrhage which does not depend upon the normal clotting mechanism. DERMICEL Surgical Tape, a special-purpose dressing tape for patients with unusual adhesive tape sensitivity, is also of particular interest. Other products, designed for your office, hospital or patient use, are also displayed. You will find well-informed representatives pleased to discuss these products or provide information on any other items made available by the world's largest manufacturer of surgical dressings and baby products.

Knoll Pharmaceutical Company **Booth No. 413**
Orange, N. J.

DILAUDID cough syrup for "the cough that must be controlled"; also DILAUDID ampules for pain that synthetic analgesics frequently fail to relieve. NICOMETRAZOL elixir and tablets have increased the scope of oral METRAZOL therapy, a field in which METRAZOL and Vita-METRAZOL are widely and successfully used in fatigue, geriatric and convalescent patients. QUADRINAL suspension and tablets for asthma. AKINETON tablets and ampules—the new agent for parkinsonism.

A. Kuhlman & Company **Booth No. 402**
Detroit, Mich.

The A. Kuhlman & Company cordially invites you to visit our exhibit where we will have several representatives on hand to discuss with you our complete line of examining room furniture, diagnostic instruments, surgical instruments, and physical therapy equipment.

Lederle Laboratories **Booth No. P-3**
Pearl River, N. Y.

Your Lederle representative will be on hand to serve you. He can furnish information on any Lederle product and is prepared to bring to bear on any of your medical problems the knowledge of the world-wide Lederle research organization.

Eli Lilly & Company **Booth Nos. 517-519**
Indianapolis, Ind.

You are cordially invited to visit the Lilly exhibit located in space Nos. 517 and 519. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

J. B. Lippincott Company **Booth No. P-4**
Philadelphia, Pa.

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

Lloyd Brothers, Inc. **Booth No. 411**
Cincinnati, Ohio

Welcome to the Lloyd Brothers exhibit. Our professionally trained sales representatives will be pleased to greet you and discuss the merits of our products in your practice. Of particular interest will be a new booklet on erythropoietin, the erythropoietic hormone.

P. Lorillard Company **Booth No. 501**
New York, N. Y.

P. Lorillard Company invites you to visit the Kent Cigarette Exhibit.
We are presenting the Story of Kent Cigarettes. And a big part of that story is why you'll feel better about smoking with the taste of Kent.
Kent with the Micronite filter refines away harsh flavor . . . refines away hot taste . . . makes the taste of a cigarette mild.
A table cigarette box with your signature in gold will be a pleasant souvenir of your visit to the Convention.

Maico Hearing Service **Booth No. 412**
Grand Rapids, Mich.

An exhibit of the latest in electronic developments relating to: Eyeglass hearing aids, behind the ear hearing aids, and barrette type hearing aids. See the latest development in Electronic Instruments for Auscultation, accomplishes what no Acoustic Stethoscope can. The latest in portable audiometers will be shown, also.

Maltbie Laboratories Division **Booth No. P-7**
Wallace & Tiernan, Inc.
Belleville, N. J.

Maltbie Laboratories features the unique tranquilizer compound, DORNWAL, impressively effective against tension headache and anxiety states. Also displayed are: CALDECORT, an antifungal, antibacterial, anti-inflamamtory dermatologic ointment; DESENEX, for athlete's foot; NESACAINE, a safe, potent and rapid-acting local anesthetic; CHOLANS, for Hepatobiliary dysfunction; and CALDESENE MEDICATED POWDER for diaper rash.

Marion Laboratories, Inc. **Booth No. 509**
Kansas City, Mo.

DUOTRATE

Cardiovascular problems requiring vasodilation can be effectively treated with less expense, less inconvenience and greater therapeutic effect. Duotrate PLATEAU CAPS provide a continuous method of drug release on a b.i.d. dosage—available in four dosage combinations. We invite you to visit our booth for information and reprints of current studies.

Marshall Erdman & Associates **Booth No. 102**
Madison, Wis.

Erdman Prefabricated Medical Buildings are the result of years of experience in the field of design, manufacturing and construction. No other company has had as extensive experience in this field. Over 500 doctors are now practicing in Erdman-built Medical Buildings. Experienced Architects, Engineers and Construction Superintendents of the Erdman Company will design, manufacture and build your Medical Building from the land-planning stage until you open the door into your own office.

S. E. Massengill Company **Booth No. 113**
Bristol, Tenn.

Best wishes from Massengill to the Michigan State Medical Society for a most successful convention!
Our representatives will welcome the opportunity to discuss products of interest to you. On display will be several Massengill specialty preparations, and literature and samples will be available, should you desire them.

Mead Johnson & Company **Booth No. 201**
Evansville, Ind.

Mead Johnson Laboratories will present its line of nutritional and pharmaceutical specialties. Featured in this presentation will be its line of formula products, including Enfamil® Liquid and Powder; vitamin supplements including the new Vi-Sol® Vitamin Drops with Iron and Vi-Sol® Chewable Vitamins as well as its new antiallergic-antipruritic Tacaryl Chewable Tablets.

Mebuco **Booth No. 513**
Mansfield, Ohio

Medco Products Company **Booth No. 419**
Tulsa, Okla.

Presenting the MEDCO-SONLATOR. Providing a new concept in therapy by combining muscle stimulation and ultra sound simultaneously through a SINGLE Three-Way Sound Applicator.

The MEDCO-SONLATOR is a distinct advance in the effectiveness of physical therapy in your office or hospital. A few minutes spent in our booth should prove of value to your practice.

Medical Arts Supply Company **Booth No. 410**
Grand Rapids, Mich.

Medical Arts Supply Co. will show in their booth at the Michigan State Medical Society Convention the new equipment as manufactured by the Air Shields Mfg. Co. Also, new Ritter and Hamilton Equipment plus a display of very fine surgical instruments.

Medical Protective Company **Booth No. 103**
Fort Wayne, Ind.

With exceptional proficiency in defense, so essential to the Doctor's protection today, The Medical Protective Company offers unexcelled coverage in any claim or suit for damages based on professional services rendered or which should have been rendered. Its experience from the successful handling of 81,000 claims and suits during 62 years of Professional Protection Exclusively is unparalleled in the professional liability field.

Merck Sharp & Dohme **Booth No. P-6**
West Point, Pa.

'LYOVAC' 'THROMBOLYSIN' fibrinolysin (human) for use to promote the dissolution of certain intravascular thrombi is featured.

'ELAVIL', a potent antidepressant agent with a low degree of toxicity, and 'DECADRON', for symptomatic treatment in patients with allergic and inflammatory disorders, are also of interest.

Technically trained personnel will be present to discuss these and other subjects of clinical interest.

Wm. S. Merrell Company **Booth No. 211**
Cincinnati, Ohio

Merrill Lynch, Pierce, Fenner & Smith **Booth No. 114**
Grand Rapids, Mich.

Stock, bond and commodity quotations available at booth by telephone from local office.
Two Account Executives in attendance to assist at all times.
Types of investment booklets available:
"Two Dozen Clues for the Doctor's Successful Investment"
"How To Invest"
"How To Buy Stocks"
et cetera

Michigan Bell Telephone Company **Booth No. 409**
Detroit, Mich.

Michigan Medical Service **Booth No. 306**
Detroit, Mich.

You are cordially invited to visit our booth to obtain current information regarding Michigan Medical Service (Blue Shield). Our representatives will gladly visit with you and answer any questions you may have with regard to your Blue Shield Plan.

Midwest Imports **Booth No. P-1**
Physical Medicine Division
Hinsdale, Ill.

The Physical Medicine Division of Midwest Imports, Hinsdale, Illinois, will exhibit the complete SIEMENS LINE, consisting of:

CARDIOMAT, electrocardiograph with automatic lead and speed marking and push-button control system;

ULTRATHERM, shortwave diathermy machines with automatic tuning and deep-field efficiency—the most advanced in this field;

SONOSTAT, ultrasonic generator featuring a dosage tabulator;

various models of electro-diagnostic and stimulation generators.

Also a complete line of diagnostic instruments.

Few minutes at our booth will prove to be of great importance to you.

Milex Products **Booth No. 115**
Oak Park, Mich.

Milex Products is pleased to announce the release of two new products: (1) a "Teen-Age Guide"; (2) a Fertility Calculator. Also on display will be the new Wide-Seal Crescent, Marital Guide, and Menopause Book, Trimo-San for Treatment Poly-Vaginal Infections, a complete Infertility Line, Amino-Cerv Creme (New Formula) and the Cancer Detection Unit.

Miller Surgical Company **Booth No. 317**
Chicago, Ill.

MILLER SURGICAL CO. Booth No. 317. See the Miller Electro-Surgical Units and accessories, such as Snares, Suction-Coagulation attachments, Grasping Forceps, etc. These Units cut, desiccate, fulgurate, coagulate and may be used for most delicate work up to light major surgery. Also a complete line of Diagnostic Equipment consisting of Illuminated Otoscope, Ophthalmoscope, Eyespud with Magnet, Transillumination Lamps, Mirror Headlite, Vaginal Speculum with Smoke Ejector and Gorsch Operating scopes and stainless steel proctoscopes, all sizes, with magnification. Available also, the Variable Wall Rayostat which converts battery operated equipment to electric.

MSMS Life, Health & Accident **Booth No. P-8**
Insurance Program
Lansing, Mich.

You are cordially invited to stop at Booth P-8 and discuss the MSMS Life, Health and Accident Insurance Program.

Representatives of the MSMS carriers will be present to answer questions concerning your MSMS group coverage.

V. Mueller & Company **Booth No. 315**
Chicago, Ill.

The life-saving Mueller-Moerch Piston Respirator—and Moerch Swivel Tracheostomy Tubes will be demonstrated by V. Mueller & Company. The new Corbin-Farnworth External-Interal Defibrillator and Pacemaker developed for the closed-chest cardiac massage technic—will also be shown.

Mullers Shoes, Inc. **Booth No. 506**
Grand Rapids, Mich.

Our exhibit will show the new Sabel Equino Varus Pre-Walker shoe with Roto-Lok Bar attachments, plus many other of Sabel's basic shoes. We shall also have on display our new line of 100% Straight Last Thomas Heel shoes.

For your interest, Doctor, we have compiled a complete catalog of all types of basic corrective footwear. Please ask us for one.

Wm. R. Niedelson Company **Booth No. 117**
Detroit, Mich.

Pulmonary function and respiratory studies with the new Jones "PULMONOR" will be discussed. "AIR-BASAL" Equipment will also be on display. Office X-Ray examining table model can be viewed.

Noble-Blackmer, Inc. **Booth No. 207**
Jackson, Mich.

You are cordially invited to visit Booth No. 207 while you are at the convention. Noble-Blackmer, Inc.'s friendly representatives will be happy to demonstrate to you the new Birtcher Compact Electrocardiograph, the ever popular 2-A-1 Ritter table, the Liebel-Flarsheim Basalmeter and Office Bovie unit, plus the latest instrument items.

Hermien Nusbaum & Associates **Booth No. 507**
Chicago, Ill.

HERMIEN NUSBAUM and ASSOCIATES, Space 507 invites you to register for samples for personal and office use:

Diaprex and Carbax—Ointments to prevent diaper rash and relieve diaper rash and other skin irritations.

Evenflo—glass and boilable plastic bottles; preemie, crosscut and silicone locking nipples; Take Home Formula Pak.

OUR BABY'S FIRST SEVEN YEARS Record Book —offers "Approach to Parenthood" for Prospective Parents Classes and office appointment cards for OB patients.

TFL Dropper—one piece, soft and flexible; will not injure or irritate. Re-usable or extendable.

Ortho Pharmaceutical Corporation **Booth No. 214**
Raritan, N. J.

On display with a complete line of products for conception control are two new forms of the new potent anti-fungal agent, SPOROSTACIN Chlordantoin: SPOROSTACIN Lotion for most forms of fungal dermatitis, and SPOROSTACIN Solution for paronychia and fungal infections of the nails. SPOROSTACIN Cream for monilial vaginitis will also be on display.

Parke, Davis & Company **Booth No. 119-121**
Detroit, Mich.

Medical service members of our staff will be in attendance at our booth to discuss important Parke-Davis specialties which will be on display.

Pfizer Laboratories **Booth No. 504**
New York, N. Y.

You are cordially invited to visit the Pfizer Laboratories' booth where our Professional Service Representatives will be pleased to discuss the latest topics of clinical interest.

Procter & Gamble Company **Booth No. 311**
Cincinnati, Ohio

Ivory Soap (Procter & Gamble) offers a series of time-saving leaflet pads for doctors, each pad containing fifty identical tear-out sheets. These sheets, which may be given to patients, contain routine instructions covering six different topics. There are also samples of other free, helpful material prepared especially for physicians. Mrs. Christyne Schwab in charge.

Professional Management **Booth No. 403**
Battle Creek, Mich.

Black & Skaggs Associates
Professional Management
A COMPLETE BUSINESS SERVICE FOR THE MEDICAL PROFESSION.

The trademark PM is the brand of distinction which identifies Professional Management offices affiliated with Black & Skaggs Associates, Inc., of Battle Creek, Michigan. It assures PM clients that the knowledge, experience and integrity of 29 years and the largest such firm in the country are at their command.

Those attending the 1961 Michigan State Medical Society Annual Session are cordially invited to stop at Booth No. 403 and meet experienced PM executives from the Battle Creek, Detroit, Grand Rapids and Saginaw offices.

Randolph Surgical Supply Company **Booth No. 217**
Detroit, Mich.

Randolph Surgical will display a new low priced quality suite of office furniture, made by a leading medical furniture manufacturer. Also, on hand to greet our many customers will be our experienced personnel.

R. J. Reynolds Tobacco Company **Booth No. 301**
Winston-Salem, N. C.

Welcome to the R. J. Reynolds Tobacco Company Exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMEL, WINSTON Filter, Menthol Fresh SALEM or CAVALIER King Size Cigarettes.

A. H. Robins Company, Inc. **Booth No. 420**
Richmond, Va.

For relieving many symptoms of the season's common colds, prescribe DIMETAPP EXTENTABS and DIMETANE EXPECTORANT. DIMETAPP EXTENTABS provide the unexcelled antihistaminic properties of *Dimetane* plus the decongestant actions of *phenylephrine* and *phenylpropanolamine*. With *glyceryl guaiacolate* these same compounds form DIMETANE EXPECTORANT.

For superior expectorant action alone, prescribe ROBITUSSIN. And for a therapeutic multivitamin, ADABEE.

Roche Laboratories **Booth No. 520**
Nutley, N. J.

LIBRIUM—A therapeutic agent for superior, safer, faster control of nervousness, anxiety, tension and other common emotional disturbances without the dulling effect or depressant action of the tranquilizers.

TIGAN—A specific antiemetic agent effective both prophylactically and therapeutically against most clinically significant types of nausea and vomiting.

J. B. Roerig & Company **Booth No. 212**
New York, N. Y.

J. B. Roerig and Company will welcome members of the medical profession at the company's exhibit of leading specialties and new products. Representatives will be in attendance to answer any questions you may have. Roerig recently introduced a number of new products which representatives at the exhibit will describe and give information on the results of clinical reports.

Wm. H. Rorer, Inc. **Booth No. 108**
Philadelphia, Pa.

MAALOX, a pleasant tasting, non-constipating antacid, is featured in Suspension, Tablets No. 1 and Tablets No. 2. Also highlighted are ASCRIPTIN, a professional salicylate for pain of arthritis, FERMA-

LOX, a non-irritating, uncoated, buffered ferrous sulfate tablet, and PAREPECTOLIN, a pleasant tasting antidiarrheal preparation of Paregoric, Pectin and Kaolin.

Representatives will gladly answer questions concerning Rorer products.

Ross Laboratories **Booth No. 105**
Columbus, Ohio

Ross Laboratories, manufacturer of Similac, features SIMILAC WITH IRON, supplying 12 mg. of ferrous iron per quart of feeding. SIMILAC WITH IRON is designed for use when exogenous iron is indicated in infancy to support the usual diet, and to provide prophylaxis against iron depletion starting about the fourth month or 14 pounds. The newest booklet in the Ross Developmental Aids will be on display at the booth.

C. J. Rouser Supply Company **Booth No. 209**
Lansing, Mich.

Superior ventilation and pulmonary treatment are easily achieved with the new Simplex model of the Bird Mark 7 Respirator. Long-time management of Cystic Fibrosis-Chronic Bronchospasm-Emphysema. Many of these treatments are now being given in the doctor's office.

Also Micronefrin Bird's new Bronchodilator and Jone's Pulmonor for Simplified Waterless Pulmonary Function Testing.

Rupp & Bowman Company **Booth No. 405**
Highland Park, Mich.

Doctors, you are cordially invited to stop in at our booth. Hope to have new items of interest to you.

Sanborn Company **Booth No. 516**
Waltham, Mass.

The new SANBORN/FROMMER CELL COUNTER as well as new ELECTROCARDIOGRAPHS of advanced design and function together with the latest models of other instruments for diagnostic use, will be displayed and demonstrated at the Sanborn Company Booth No. 516.

Demonstrations and/or data will also be available on Sanborn instruments for biophysical research—single and multi-channel recording systems, monitoring oscilloscopes and physiological transducers.

Qualified Sanborn representatives will be pleased to answer questions and assist you with technical problems.

Sandoz Pharmaceuticals **Booth No. 318**
Hanover, N. J.

Sandoz Pharmaceuticals cordially invites you to visit our display at Booth No. 318.

MELLARIL—the first potent tranquilizer with a selective action (i.e.—no action on vomiting centers). This unique action gives specific psychic relaxation with safety at all dosage levels.

TORECAN—as a sequel to the original research which led to the synthesis of Mellaril, a tranquilizer relatively devoid of antiemetic activity, the Sandoz Laboratories have now succeeded in developing a potent antiemetic with little or no tranquilizing properties. Accordingly, this compound, *TORECAN,* constitutes a more specific antiemetic and the results obtained to date indicate that it is a promising agent for the treatment of nausea and emesis of diverse etiology.

CAFERGOT PB—the most effective oral medication for the relief of migraine headache with G. I. disturbance accompanied by tension.

Any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

W. B. Saunders Company **Booth No. P-2**
Philadelphia, Pa.

Harold Rozema will again be on hand with the complete Saunders line. New titles since last year's meeting include: Edwards: Atlas of Heart Disease; Pillsbury et al: Dermatology; White: Kidney Diseases; Sodeman: Pathologic Physiology; Rubin: Diseases of the Chest; and Tenney & Little: Clinical Obstetrics.

Julius Schmid, Inc. **Booth No. 407**
New York, N. Y.

An interesting and informative exhibit featuring IMMOLIN Vaginal Cream-Jel for use without a diaphragm; RAMSES Flexible Cushioned and BENDEX Diaphragm; Ramses Vaginal Jelly; VAGISEC Jelly and Liquid for vaginal trichomoniasis therapy; and XXXX (FOUREX) Skin Condoms, RAMSES, SHEIK and ESQUIRE Rubber Condoms for the control of trichomonal re-infection.

G. D. Searle & Company **Booth No. P-16**
Chicago, Ill.

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Smith, Kline & French Laboratories **Booth No. P-5**
Philadelphia, Pa.

Our Representatives welcome the opportunity to discuss SK&F products with you and are always ready to be of help in any way they can. Products featured are: (1) Stelazine® Tablets; (2) Parnate® Tablets; (3) Eskatrol® Spansule® capsules; (4) Thorazine®; (5) Ornade® Spansule® capsules.

E. R. Squibb & Sons **Booth No. 308**
New York, N. Y.

E. R. Squibb & Sons has long been a leader in development in new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the Medical Profession in new products or improvements in products already marketed.

At Booth No. 308, we are pleased to present up-to-date information on these advances for your consideration.

Standard Process Laboratories **Booth No. 417**
Milwaukee, Wis.

Standard Process Laboratories will feature Ribo Nucleic Acid and Enzyme formulas for treating Chronic and Degenerative diseases, including Proteolytic Enzyme therapy, for complete protein breakdown, making the amino acids available to Geriatrics; also three different HCl formulas for Hypochlorhydria cases. Some new digestive formulas, containing all natural elements acceptable to the digestive system, may also be displayed.

Strasenburgh Laboratories **Booth No. P-17**
Rochester, N. Y.

You will learn—

How 'Biphetamine', 'Ionamin', and 'Biphetamine-T' can assist in achieving sustained weight loss in exogenous obesity!

How a single dose of 'Tussionex' will control coughs for 8-12 hours!

How 'Akalon-T' provides 8-12 hours relief from the pain of hyperacidity and hypermotility!

How sustained ionic release (Strasionic Release) makes all five of these products unique and effective!

The Stuart Company **Booth No. P-18**
Pasadena, Calif.

A cordial invitation is extended to all members and guests attending this meeting to visit the Stuart Company booth. Specially trained representatives will be

in attendance to answer your questions on new products developed in our new and modern laboratories which have received international acclaim.

Testagar & Company **Booth No. 408**
Detroit, Mich.

Testagar & Co. invites you to stop at Booth 408 to see the newest release, "Redoderlein—Replacement Doderlein Bacillus Therapy." Doderlein Bacillus is a recognized therapy in convenient, stable, readily available form. Redoderlein may be the therapy of choice in vaginitis; trichomonas, monilial, senile or nonspecific. Stop at Booth 408 and receive literature on the newest concept in the treatment of vaginitis.

S. J. Tutag & Company **Booth No. 418**
Detroit, Mich.

S. J. Tutag & Company will exhibit Cydril, the new anti-obesity product exhibiting low CNS stimulation properties. Information regarding other Tutag quality products will be available. Our representatives will be pleased to meet you and answer your questions.

U. S. Vitamin & Pharmaceutical Corp. **Booth No. 515**
New York, N. Y.

D B I, "full-range" oral hypoglycemic agent, is a brand of phenformin (N^1-B-phenethylbiguanide). D B I is distinctly different in chemical structure and physiologic action from the oral hypoglycemic sulfonylureas, and effectively lowers blood sugar in mild, moderate and severe diabetes. D B I, used alone, satisfactorily lowers elevated blood sugars in as high as 88 per cent of stable adult diabetics . . . and successfully restores to oral control significant numbers of primary and secondary sulfonylurea failures. In combination with insulin, D B I improves regulation of "brittle" adult and juvenile diabetes and is also effective in many insulin-resistant cases. Full details available.

The Upjohn Company **Booth No. P-13**
Kalamazoo, Mich.

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

Vaponefrin Company **Booth No. 310**
New York, N. Y.

Wallace Laboratories **Booth No. 312**
New Brunswick, N. J.

Warren-Teed Products Company **Booth No. 518**
Columbus, Ohio

The Warren-Teed Products Company will feature the following pharmaceutical specialty products at their exhibit.

Ilocalm Tablets—Antiulcerogenic plus anticholinergic management of peptic ulceration.

Ilomel Powder—Antiulcerogenic plus antacid management of peptic ulceration.

Ilopan—An injectable d-pantothenyl alcohol for the treatment and prevention of flatulent gastrointestinal distention.

Warren-Teed representatives cordially welcome all registrants to visit their display.

Westwood Pharmaceuticals **Booth No. 307**
Buffalo, N. Y.

Westwood invites physicians to stop by their booth to discuss their unique dermatological products:

Fostex Cream	Lowila Cake	Sebulex
Fostex Cake	Lowila Emollient	Fostril
		Alpha-Keri

These products are particularly suitable for personal use by physicians and their families who may be plagued with dandruff, acne, dry and itchy skin, and sensitivities to soap. Register, so that we may send prescription units to your home.

White Laboratories **Booth No. 204**
Kenilworth, N. J.

White Laboratories exhibit features Sorboquel tablets —the result of a decade of laboratory experimentation and over five years of clinical confirmation. Sorboquel, a totally new agent for truly effective control of both chronic and acute diarrhea, has been demonstrated effective in 85% of chronic and 94% of acute cases of diarrhea.

This exhibit also features Entoquel Syrup. A new gastrointestinal antimotility agent for fast, effective, and economical treatment of pediatric diarrhea. Entoquel is not an opiate, and has successfully stopped diarrhea where kaolin pectin suspension has failed.

Winthrop Laboratories **Booth No. 406**
New York, N. Y.

Trancoprin, a new non-narcotic analgesic which relieves pain and relaxes skeletal muscle spasm safely and effectively. It also has a mild tranquilizing effect.

Isuprel Elixir, a new balanced expectorant bronchodilator which contains three antiasthmatics—Isuprel, ephedrine, theophylline—with the expectorant, potassium iodide, and Luminal for a mild sedative effect.

Call to Arms

Detroit Medical News, June 12, 1961

We have heard it said that people may be divided into three kinds. First, the very small number who make things happen; second, the somewhat larger number of people—the intelligent, well-informed, educated people, who watch things happen; and finally the largest segment—those who don't know anything is happening.

Physicians, as a rule, are among the most educated people in their community. Their daily association with humanity with its mask off, increases their sensitivity, insight and sense of reality.

However, there is in our educational process the "scientific" method of training ourselves to see all sides of every question. This is valuable, but we have failed to take the next logical step. After seeing all sides, we are *obligated*, if we want anything to happen, to decide in favor of one stand and to know the reasons why. Many of us are so tolerant of all views that we have none of our own which we are willing to fight for. Meanwhile, those who take a stand and fight for it with a passion are the ones who change the course of human events. It is time for physicians with their unique gifts to examine in detail all their personal values, weigh them carefully, then decide where to stand, and come up fighting.

Let's stop being watchers. Let's make things happen.

in rheumatoid arthritis

Aristocort®

Triamcinolone LEDERLE

UNSURPASSED "GENERAL-PURPOSE" STEROID
OUTSTANDING FOR "SPECIAL-PURPOSE" THERAPY

ARISTOCORT Triamcinolone has long since proved its *unsurpassed efficacy and relative safety* in treating rheumatoid arthritis. Mounting clinical evidence has shown that ARISTOCORT is also highly valuable for the "special-problem" arthritic – the patient who, because of certain complications, was hitherto considered a poor candidate for corticosteroids.

for example:

SPECIAL PROBLEM: ANXIETY-TENSION

When triamcinolone was used, euphoria and psychic unrest rarely occurred. (McGavack, T. H.: *Clin. Med.* 6:997 [June] 1959.)

SPECIAL PROBLEM: OVERWEIGHT

No patient developed voracious appetite on triamcinolone. Preferable for the overweight person whose appetite is undesirably stimulated by other steroids. (Freyberg, R. H.; Berntsen, C. A., Jr., and Hellman, L.: *Arthritis & Rheumatism* 1:215 [June] 1958.)

SPECIAL PROBLEM: EDEMA

Since it does not produce edema, triamcinolone is useful in rheumatoid arthritis patients with cardiac decompensation who need steroid therapy. (Hollander, J. L.: *J.A.M.A.* 172:306 [Jan. 23] 1960.)

SPECIAL PROBLEM: HYPERTENSION

Triamcinolone may be included among the currently available antirheumatic steroids having the least tendency to cause sodium retention. (Ward, L. E.: *J.A.M.A.* 170:1318 [July 11] 1959.)

Hypertension did not result from triamcinolone therapy. Existing hypertension was reduced sometimes. This may have been due to lack of sodium retention. (Freyberg, R. H.; Berntsen, C. A., Jr., and Hellman, L.: *Arthritis & Rheumatism* 1:215 [June] 1958.)

Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. In the treatment of rheumatoid arthritis, dosage should be individualized and kept at the lowest level needed to control symptoms. Dosage should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

Supplied: Scored tablets—1 mg. (yellow); 2 mg. (pink); 4 mg. (white); 16 mg. (white).
Also available—syrup, parenteral and various topical forms.

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MICHIGAN DEPARTMENT OF HEALTH

ALBERT E. HEUSTIS M.D., State Health Commissioner

Division of Laboratories to Discontinue Some Services

Effective July 3, 1961, the Division of Laboratories will discontinue the performance of blood groupings, Rh type determinations, anti-Rh and ABO titrations, and all blood and urine chemistry determinations.

This change *will not* affect those state institutions which do not have their own laboratory facilities or those agencies with whom the state health department has contractual agreements.

Organizational Changes

As of July 3, 1961, the Division of Disease Control, Records and Statistics was abolished. In its place, the Division of Epidemiology was established under the direction of Dr. George Agate. The Sections of Vital Records and of Statistical Methods have been transferred to the Division of General Services (formerly Administrative Services) and the Section of Education has been transferred from the Division of General Services and has become the Office of Public Health Information Services.

Diabetes Detection

In the first three months of this year, 7,833 persons were screened for diabetes in Detroit. As a result of these screening tests, thirty persons were found to have diabetes without knowing it. Data from this program substantiate the fact that diabetes is found much more frequently as people get older. The rate for new cases diagnosed increased from 2.0 per 1,000 in the age group 20-44 to 15.9 per 1,000 in the age group 75-84.

Grant-in-Aid

The establishment of a grant-in-aid entitled "The Isolation of Human Placental Fibrinolysin" was approved by the National Institutes of Health for a two-year period from May, 1960, through April 1963. The purposes of the investigation are:

1. To develop procedures for the isolation and purification of profibrinolysin (plasminogen) from hemolyzed placental and intrapartum blood;
2. To study some of profibrinolysin's chemical and physical properties and to study its conversion to the active fibrinolytic principles, fibrinolysin (plasmin); and
3. To make both profibrinolysin and fibrinolysin available in sufficient quantity and quality for (a) use by ourselves and regulating agencies as reference laboratory standards and (b) its *in vitro* and *in vivo* evaluation as a thrombolytic agent.

Antibiotic Research

Research continues in the development of new and useful antibiotics. A total of 14,622 samples of antibiotic substances has now been submitted to the National Cancer Institute for screening against cancer cells. Of these, sixty-seven have shown marked anti-cancer activity. Ten substances were eliminated as being impractical. Twelve substances are now being developed for more advanced investigation.

Conductive Flooring in Hospitals

The department is continuing to study the failure of conductive flooring used in hospital operating and delivery rooms. Testing during May indicated that terrazzo conductive flooring in a new hospital did not meet safety standards. This discovery was made prior to the opening of the hospital. Visits to two other hospitals with the same type of flooring constructed within the past two years indicated that attempts to rejuvenate this flooring have so far failed. The problem has been called to the attention of the flooring contractors, Terrazzo Institute, the National Fire Protection Association, and the State Fire Marshal.

Discontinue Measuring Fallout

After six years of round-the-clock monitoring, the Michigan Department of Health discontinued measuring radioactive fallout on June 11, this year. The monitoring was halted because readings over the past one and one-half years have remained at normal levels since the cessation of nuclear testing.

During the six years in which fallout was monitored, it was determined that Michigan is in a higher than average fallout area. However, although there were sharp increases in fallout over Michigan during nuclear testing periods, concentrations never reached levels considered dangerous by established standards. If nuclear testing should be resumed in the future, the department will again begin to measure radioactive fallout.

Many from Michigan On AMA Program in NYC

Medical discipline, surgical assistants, drug legislation, relations with allied health professions and services, and many other subjects were covered by 115 resolutions and 28 reports acted upon by the House of Delegates at the American Medical Association's 110th Annual Meeting held June 25-30 in New York City.

George M. Fister, M.D., of Ogden, Utah, member of the AMA Board of Trustees, was named president-elect of the Association. Dr. Fister will become president at the June, 1962, annual meeting in Chicago, succeeding Leonard W. Larson, M.D., of Bismarck, North Dakota, who assumed office in New York.

The AMA 1961 Distinguished Service Award was voted to Walter H. Judd, M.D., of Minneapolis, physician and member of Congress, for his contributions as a medical missionary, humanitarian and statesman devoted to world peace.

* * *

THE SCIENTIFIC PROGRAM of the American Medical Association Annual Session is in reality the raison d'etre of the convention. The administrative and legislative affairs are indispensable, and have received brief consideration considering their importance.

Many physicians from Michigan devoted their time and made their contributions. Those listed had some part in presenting papers, moderating panels, taking part in formal discussions, in the exhibits, and as section officers. Unless otherwise mentioned, the following are all M.D.'s:

From Ann Arbor: William H. Beierwaltes, Leonard F. Bender, Edward A. Carr, Arthur C. Curtis, Winthrop N. Davey, Russell N. DeJong, Marion S. DeWeese, Ivan F. Duff, Harold F. Falls, Conrad L. Giles, Richard J. Ging, Karen A. Gustafson, Thomas P. Haynie, James H. Heakaman, Gerald Hover, Jo D. Isaacson, William Martel, James G. Miller, Seward E. Miller, George W. Morley, Mohammed M. Noral, Julius A. Parker, M.A.; H. Marvin Pollard, James W. Rae, Jr., William W. Tourtellotte, Ph.D., Albert H. Wheeler, Ph.D., Chris J. D. Zaraeonetis.

From Detroit: Walter L. Anderson, D. F. Armento, J. E. Berk, Richard J. Bing, A. W. Bohne, George C. Bower, J. B. Bryan, Lucian Campeau, Max D. Clark, Wyman C. C. Cole, Sr., William R. Eyler, Robert P. Fosnaugh, Boy Frame, Michael C. Geokas, Robert A. Gerisch, James H. Greer, Ph.D., R. J. Hartsock, C. Paul Hodgkinson, Robert Horn, Jr., W. Leonard Howard (Northville), Funan Hu, R. Ross Hume, R. B. Hunter, Aran S. Johnson, H. L. Johnson, Kenneth L. Krabbenhoft, Edward A. Krull, Conrad R. Lam, Traian Leucutia, Clarence S. Livingood, W. L. Lowrie, Lucile Marsh, Amir H. Mehregan, Richard R. Menard, W. C. Mieher, Robert C. Moehle, R. S. Ormond, Herman Pincus, Dwight H. Porter, W. E. Redfern, Roger I. Rian, Walter H. Seegers, Ph.D., Edward J. Shumaker, John W. Sigler, R. D. Urwiller, George L. Waldbott, F. W. Whitehouse.



FOLLOWING ARE brief descriptions of some of the AMA actions:

Medical Discipline

As a major move designed to strengthen the profession's disciplinary mechanisms, the House approved the conclusions and recommendations of the Medical Disciplinary Committee, with only three word changes.

One recommendation suggests that "The bylaws of the American Medical Association be changed to confer original jurisdiction on the Association to suspend or revoke the AMA membership of a physician guilty of a violation of the Principles of Medical Ethics or the ethical policy of the American Medical Association regardless of whether action has been taken against him at local level."

Another "encourages and urges that each state association report annually to the American Medical Association all major disciplinary actions taken within its jurisdiction during the preceding calendar year." The report urged state and county medical societies to utilize grievance committees as "grand juries" to initiate action against an offender so as to obviate the necessity of making an individual member of a medical society complain against a fellow member.

Communications

The House adopted a substitute resolution directing the Speaker of the House of Delegates to name seven elected members of the House as a special committee "to study and continually advise the Board of Trustees on the broad planning and coordination of all phases of communications of the American Medical Association, so that the public and the members of the medical profession are properly and adequately advised of the policies and concern of the medical profession with respect to all phases and aspects of medical care for all people." The House agreed with a reference committee opinion that "we have a very adequate Division within the AMA capable of implementing any program of communications."

Surgical Assistants

The House approved the following five basic principles developed by the Judicial Council and the Council on Medical Service:

"1. Each member of the AMA is expected to observe the Principles of Medical Ethics in every aspect of his professional practice.

"2. Each doctor engaged in the care of the patient is entitled to compensation commensurate with the value of the services he has personally rendered.

"3. No doctor should bill or be paid for a service which he does not perform; mere referral does not constitute a professional service for which a professional



charge should be made or for which a fee may be ethically paid or received.

"4. It is ethically permissible for a surgeon to employ other physicians to assist him in the performance of a surgical procedure and to pay a reasonable amount for such assistance.

"This principle applies whether or not an assisting physician is the referring doctor and whether he is on a per-case or full-time basis. The controlling factor is the status of the assisting physician. If the practice is a subterfuge to split fees or to divide an insurance benefit, or if the physician is not actually employed and used as a bona fide assistant, then the practice is contrary to ethical principles.

"5. Under all other circumstances where services are rendered by more than one physician, each physician should submit his own bill to the patient and be compensated separately."

Efficacy of Drugs

The House strongly endorsed a Board report which pointed out the problems that would result from amending the Food, Drug and Cosmetic Act to authorize the Food and Drug Administration to determine the efficacy, as well as the safety, of a prescription drug prior to the approval of a new drug application. The report contended that "a decision with respect to the effectiveness of drugs is dependent upon extended research, experimentation and usage." The House agreed that vesting such authority in the Food and Drug Administration would operate to limit research, the marketing of drugs and the exercise of discretion by the medical profession.

General Practice Residencies

Eight resolutions were introduced on the subject of creating new two-year, residency training programs in general practice. The House agreed that there appears to be a need for such programs for those individuals who desire more experience in obstetrics and surgery than may be available in the currently existing Family Practice Program. It approved a substitute resolution directing the Council on Medical Education and Hospitals to consider for approval other two-year programs in general practice which incorporate experience in obstetrics and surgery.

Relations with Other Health Professions and Services

The House considered a Board report and twelve resolutions dealing with various aspects of medicine's relationships with allied health professions and services, including optometry. The Board report recommended the creation of a new AMA Council to handle all the problems involved. The House, however, accepted a

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reference committee suggestion for establishment of a new Commission to Coordinate the Relationships of Medicine with Allied Health Professions and Services, with subcommittees to consider problems in specific areas.

Polio Vaccine

The House approved a report by the Council on Drugs on the present status of poliomyelitis vaccination in the United States and urged that it be made available to all physicians through the most effective communications media. The report emphasizes that "physicians should encourage, support and extend the use of Salk vaccine on the widest possible scale at least until the oral polio-virus vaccines currently under development and clinical trial become available."

Osteopathy

In considering a report of the Judicial Council and three resolutions on the subject of osteopathy, the House of Delegates agreed with the intent of the report and resolutions, but instead adopted the following statement of AMA policy:

"1. There can never be an ethical relationship between a doctor of medicine and a cultist, that is, one who does not practice a system of healing founded on a scientific basis.

"2. There can never be a majority party and a minority party in any science. There cannot be two distinct sciences of medicine or two different, yet equally valid systems of medical practice.

"3. Recognition should be given to the transition presently occurring in osteopathy, which is evidence of an attempt by a significant number of those practicing osteopathic medicine to give their patients scientific medical care. This transition should be encouraged so that the evolutionary process can be expedited.

"4. It is appropriate for the American Medical Association to *reappraise its application of policy* regarding relationships with doctors of osteopathy, in view of the transition of osteopathy into osteopathic medicine, in view of the fact that the colleges of osteopathy have modeled their curricula after medical schools, in view of the almost complete lack of osteopathic literature and the reliance of osteopaths on and use of medical literature, and in view of the fact that many doctors of osteopathy are no longer practicing osteopathy.

"5. Policy should now be applied individually at state level according to the facts as they exist. Heretofore, this policy has been applied collectively at national level. The test now should be: Does the individual doctor of osteopathy practice osteopathy, or does he in fact practice a method of healing founded on a scientific basis? If he practices osteopathy, he practices a cult system of healing and all voluntary professional associations with him are unethical. If he bases his practice on the same scientific principles as those adhered to by members of the AMA, voluntary professional relationship with him should not be deemed unethical."

Miscellaneous Actions

In dealing with resolutions and reports on a wide variety of other subjects, the House also:

Approved the "*Guides to Physician Relationships with Medical Care Plans*," submitted by the Council on Medical Service, with two changes;

Reaffirmed its support of the *Kerr-Mills* program for the needy and near-needy aged and its opposition to any legislation of the *King-Anderson* type, declaring that the medical profession "will not be a willing party to implementing any system which we believe to be detrimental to the public welfare";

Approved a markedly expanded *drug information program* submitted by the Board of Trustees and the Council on Drugs;

Decided to hold the *1963 Clinical Meeting* in Portland, Oregon, instead of Las Vegas, Nevada, as recommended by the Board;

Approved a plan by the new AMA Department of International Health to cooperate in the recruitment of volunteer physicians for emergency medical service in *foreign mission fields*;

Agreed to an increase of $20 in the annual AMA *membership dues* to be implemented over a period of two years: $10 on January 1, 1962, and $10 additional on January 1, 1963;

Discontinued the Association's *General Practitioner of the Year* award;

Opposed legislative and administrative mandates which would compel physicians to prescribe drugs, or require pharmaceuticals to be sold, by *generic names* only;

Reaffirmed the Association's opposition to compulsory inclusion of physicians under the *Social Security* system;

Urged immediate legislation that will provide strong economic motivation for the construction and maintenance of *fallout shelters*;

Disapproved two resolutions which would have discontinued the scientific activities at the *Clinical Meeting*;

Urged *immunization campaigns* against both tetanus and influenza, and

Asked state and county medical societies to give full support to the *First National Congress on Medical Quackery* to be jointly sponsored next October 6-7 in Washington, D. C., by the AMA and the Food and Drug Administration.

The seventeenth Annual Conference of Presidents and Other Officers of State Medical Associations drew the largest and most enthusiastic attendance in its history.

Tell School Counselors Needs of Professions

Channels of communication were widened and deepened between high school counselors and the professions at a summer conference sponsored by the Michigan Association of the Professions.

Several leaders of the Michigan State Medical Society along with other professional society representatives participated in the week-end conference held at Alma College.

* * *

ONE OF THE MAJOR speakers was Lyman J. Smith, Ph.D., new director of the AMA scholarships program. He related his experiences as the former director of the Illinois Scholarships Commission and outlined his AMA plans. Earle S. Oldham, M.D., Breckenridge, MSMS councilor, served as official host for Mr. Smith.

The "MAP Conference with School Counselors" was developed by the MAP Committee on Education and was endorsed at the Second MAP Congress. Serving on the Committee on Education, which this spring also held a Professions Career Day at Saginaw, are William N. Hubbard, M.D., dean of the University of Michigan medical school, and Dean Gordon H. Scott of the Wayne State University medical school.

Participating in the conference with the deans or their representatives were counselors and professional men. The counselors represented junior-high, senior-high and college levels.

Working closely with MAP to present the conference were the leaders of the Michigan Counselors Association. Contributing to a conference panel discussion was Donald Fink, of Grand Rapids, president of the Counselors organization.

In addition to the speakers, panels and workshops, the conference featured an exhibit of available materials from the various professions. The counselors voiced their appreciation for these "helps."

Timed with the conference, the scholarship and recruiting committees of several of the state professional organizations met at Alma on the same days.

* * *

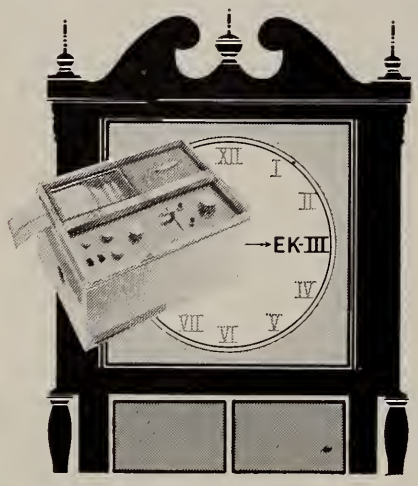
THE CONFERENCE CONCLUDED with a workshop session, when all participants stressed their desire to have another conference in 1962. It was suggested that the conference be held during the school year, in the spring, to permit more counselors to attend.

Various year-around, on-going activities were suggested by both the counselors and the professional men. William R. Mann, D.D.S., of the University of Michigan Dental School and chairman of the MAP Committee on Education, has assured that many of these activities will be pursued. Dr. Mann, in his remarks, thanks members of his committee and Alma College officials for their excellent cooperation in presenting this project.



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Hospital Representatives Attack MCCC Payments

Representatives of the Michigan Hospital Association made an appeal that hospitals rendering care under the provisions of the Michigan Crippled and Afflicted Children's Act "should be reimbursed at the cost of providing such care."

The statements were made June 29 at the hearing of the Joint Legislative Interim Committee to Review the Administration of the MCCC program.

The hospital officials contended that Michigan hospitals have lost over $10 million in the past 10 to 15 years because the MCCC reimbursement does not meet the costs.

The officials pointed out that the losses have to be recovered and that "generally speaking, these losses are recovered by charging other non-governmental patients sufficiently high rates to overcome the deficit." It was reported that a study of hospital costs at a major institution showed that governmental patients met 62 per cent of the cost of their care, Blue Cross patients 100 per cent and private-paying patients met 117 per cent.

The hospital association representatives stated that "such subsidies on the part of sick patients for the care of patients who are the responsibility of government is neither fair nor equitable." Four improved payment plans were suggested.

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Brief and to the Point

ENDS LONG SERVICE—Walter H. Rozine, M.D., Morenci, recently terminated 19 years as a member of the Morenci city council. The council adopted a resolution paying tribute to Dr. Rozine's service and loyalty.

* * *

CITIZEN OF THE YEAR—A. M. Rothman, M.D., recently was honored as "East Detroit's Citizen of the Year." Doctor Rothman was nominated by the East Detroit Chamber of Commerce for the honor. His list of civic activities includes 10 years on the city's civil service board. Doctor Rothman, who began his practice in East Detroit in 1926, was lauded by the mayor as a "dedicated doctor, who gives freely of his time and energy to help people without thought of remuneration."

* * *

ON MSU PROGRAM—Four doctors were special lecturers at the recent Workshop on Rehabilitation of the Disabled Homemaker at Kellogg Center. They included John G. Bielawski, M.D., Michigan Heart Association; Raymond H. Murray, M.D., Grand Rapids; Joseph N. Schaeffer, M.D., Rehabilitation Institute, Detroit, and Robert M. Stow, M.D., Lansing.

* * *

FEATURED—Articles by several Michigan doctors are featured in the Special Gerontotherapy Issue of *The New Physician*, SAMA publication, for July. Michigan writers in the spotlight included W. N. Hubbard, Jr., M.D., dean of the University of Michigan Medical School; Clarence E. Crook, M.D., Winslow G. Fox, M.D., Frederic B. House, M.D., John Tipton, M.D., C. Howard Ross, M.D., all of Ann Arbor.

* * *

HONORED—Harry E. August, who recently completed 10 years as chief of the psychiatric outpatient department at Sinai Hospital, was honored at a dinner at the Wayne County Medical Society building. He told the group that his proudest achievement was the recent opening of the 40-bed unit at Sinai for the mentally ill with both a "night" and "day" hospital.

* * *

CITED FOR CIVIC WORK—Remus Robinson, M.D., Detroit, member of the Detroit Board of Education, received the "Physician of the Year" award recently at the meeting of the Detroit Medical Society's Annual Clinic Day.

* * *

RECOGNIZED—The recent St. Luke's Hospital intern-resident dinner at Saginaw featured the presentation of several awards. Louis D. Gomon, M.D., was named the "outstanding physician of the year" and Robert J. Toteff was honored as the "physician who had offered the most help to the house staff."

(Continued on Page 1092)



THESE 231,000 PEOPLE IN MICHIGAN NEED MEDICAL HELP

Heart disease, cancer, mental illness — everyone knows the nation's three major medical problems. Do you know that alcoholism ranks fourth? In the state of Michigan there are at least 231,000 alcoholics. These people need medical help. No one is in a better position to initiate and supervise a program of rehabilitation than the physician who enjoys the confidence of the patient or the patient's family.

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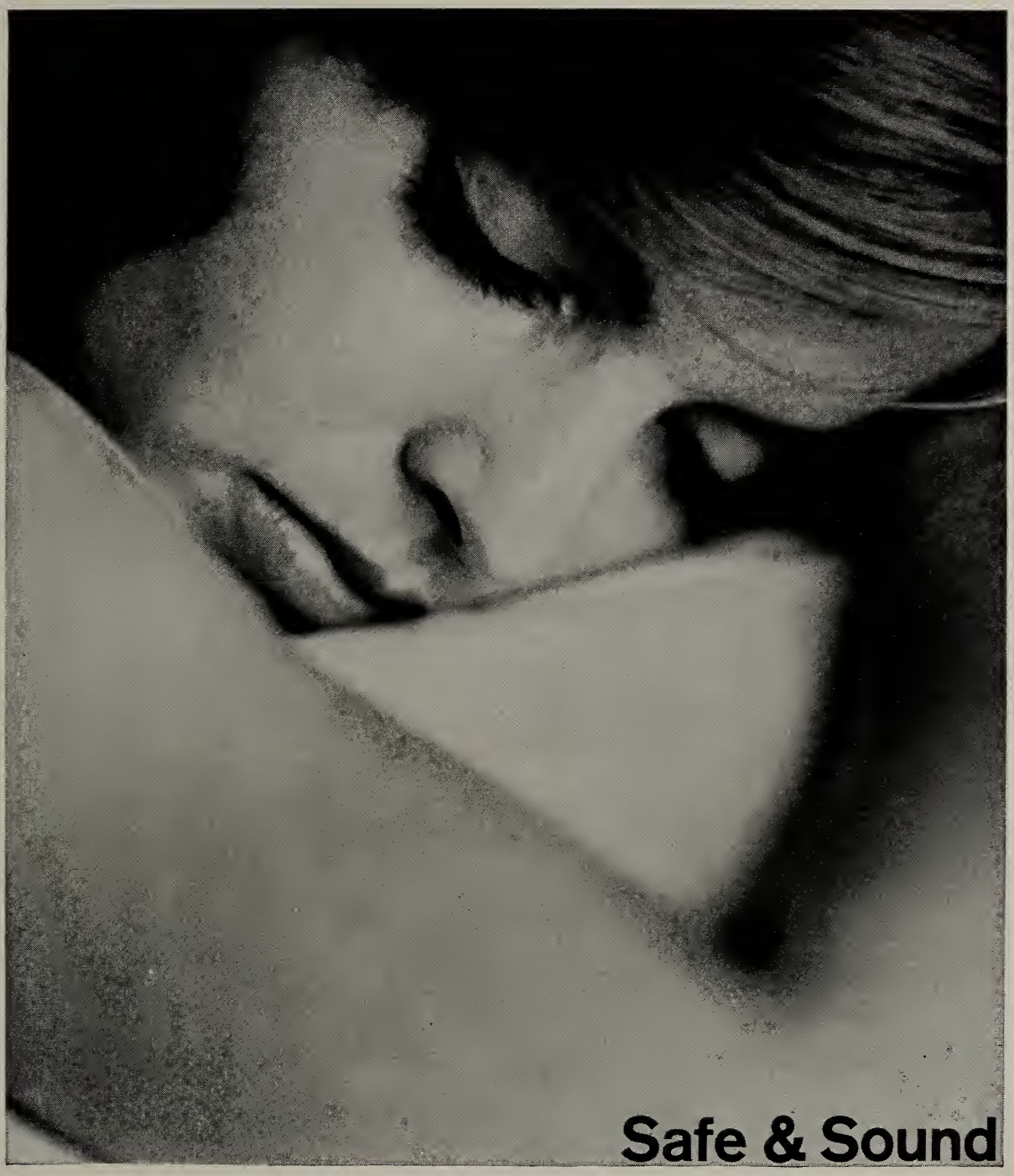
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(Continued from Page 1089)

HONORED—A. Hazen Prize, M.D., Detroit, Chairman of the MSMS Geriatrics Committee, was presented a citation for outstanding service to older people at the University of Michigan's 14th annual Conference on Aging. The citation presented read in part "skilled in the arts of your profession and dedicated to your community and to your state, your leadership in the field of aging has brought enormous benefit to the older people of Michigan."

* * *

OFFERS SCHOLARSHIPS—The Oklahoma State Medical Association has established a loan and scholarship fund at the University of Oklahoma School of Medicine supported by a $5 increase in annual dues. Assessment is expected to yield $7,500 per year, with $3 of each $5 collected earmarked for loans and $2 for scholarships and grants-in-aid.

* * *

ORDERS SAFETY BELTS—Connecticut's Governor ordered all new cars purchased by the state from now on to be equipped with safety belt mountings. He believes belts will help reduce injuries as well as costs of state compensation and insurance claims.

* * *

QUIZ HOSPITALS—Several Michigan hospitals are being surveyed by the Hospital Planning Association of Allegheny County study of community health activities at general hospitals. The purpose of the study is to determine what factors make hospitals centers of health activities in their communities and the kinds of services offered in these centers.

* * *

RESEARCH FELLOWSHIPS—Summer research fellowships for $500 were again offered by the Tobacco Industry Research Committee. "This program, now in its seventh year, is designed to encourage students to make a career in research. For those who enter other fields of medicine, it will provide valuable exposure to research," according to the committee.

* * *

NURSING HOME STUDY—The University of Michigan has launched a two-year study of nursing home costs. The purpose of the study is to find the cost of the patient services that can and should be provided by nursing homes. This is necessary for evaluating and perhaps revising payment policies to such institutions. The Social Security Administration has given $32,729 to support the first year of the investigation.

* * *

LOCATED—M.D. Locations in Michigan in March, April, May, June, as recorded by the Michigan Health Council:

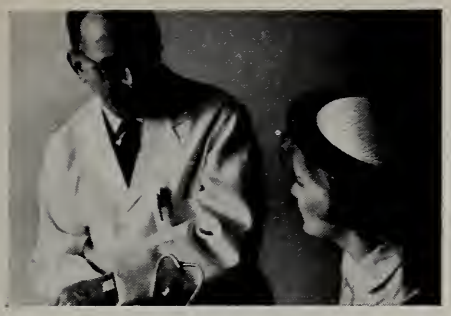
Placed by Michigan Health Council: David B. Witte, M.D., in South Haven, Alex E. Solik, M.D., in Flint, Robert Sosa, M.D., in Ishpeming, Kenneth T. Woodsides, M.D., in Albion, and Alvin J. Ratzlaff, M.D., in Hart.

Assisted by Michigan Health Council: John A. Lusk, M.D., in Davison.

* * *

DETAILS AVAILABLE—The American Board of Obstetrics and Gynecology will hold its next scheduled examination, (Part I), written, held in various cities January 5,

(Continued on Page 1094)



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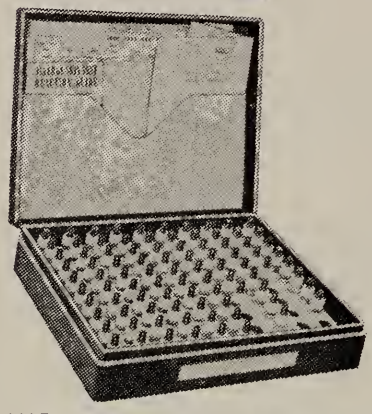


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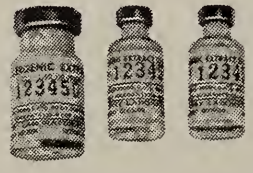
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(Continued from Page 1092)

1952. Information may be obtained from Robert L. Faulkner, M.D., Executive Secretary and Treasurer, 2105 Adelbert Road, Cleveland 6, Ohio.

* * *

FOUR-YEAR SCHOLARSHIP—Harold H. Brazil, Detroit, has received one of nine four-year medical scholarships awarded by National Medical Fellowships, Inc., a non-profit organization which provides assistance to Negroes for education and training in medicine. Individual winners will receive annual awards ranging from $400 to $1250.

* * *

PAYMENTS INCREASE—"The $731,131,187 paid to physicians by the 74 Blue Shield plans represented an all-time high for a one-year period," reports John W. Castellucci, executive vice president of the national association. The national association indicated that Blue Shield payments to the medical profession had increased from nearly $116,000,000 in 1950 to the 1960 figure of $731,131,187.

* * *

RESEARCH GRANTS—Gifts and grants totaling $470,300 were accepted recently by Wayne State University's Board of Governors. The largest amount was $307,040 from the U. S. Public Health Service, National Institutes of Health, for 10 training and research projects. The National Fund for Medical Education gave $37,440 to supplement the instructional and research program.

* * *

SPEAKS TO PHARMACISTS—Sidney E. Chapin, M.D., Dearborn, president of the Michigan Health Council, discussed the dangers of socialized medicine at the 78th annual convention of the Michigan State Pharmaceutical Association in Muskegon. Another highlight was an exhibit on child safety by the Michigan Health Council in cooperation with the President's Program of MSMS.

* * *

STEP UP CAMPAIGN—The Colorado State Medical Society has voted a $50-a-member assessment to build a fund "to educate the public and some members of the medical profession" on health needs of the aged.

The assessment is expected to raise more than $50,000 for the educational program. The money will pay for literature and for expenses of speakers to point up advantages of the Kerr-Mills Act over the King-Anderson bill now before Congress.

* * *

MEDICAL MEETINGS, USA

American Hospital Association, Sept. 25-28, Atlantic City, New Jersey.

College of American Pathologists, Sept. 30-Oct. 3, Seattle, Washington.

American Society of Clinical Pathologists, Sept. 30-Oct. 8, Olympic Hotel, Seattle, Washington.

College of American Pathologists, Oct. 1-7, Olympic Hotel, Seattle, Washington.

American Academy of Pediatrics, Oct. 2-5, Palmer House, Chicago, Illinois.

American College of Surgeons, Oct. 2-6, Conrad Hilton Hotel, Chicago, Illinois.

American Academy of Ophthalmology and Otolaryngology, Oct. 8-13, Palmer House, Chicago, Illinois.

(Continued on Page 1096)



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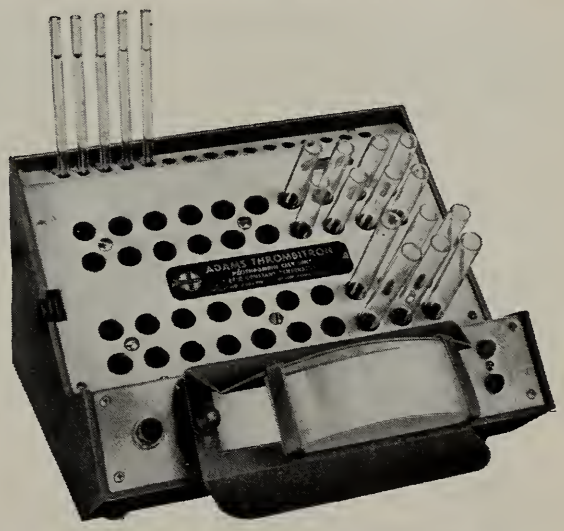
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(Continued from Page 1094)

Fourth International Congress of Allergology, Oct. 15-20, the Hotel Commodore, New York, N. Y.

American Heart Association, 34th Annual Meeting, Oct. 20-24, Miami Beach, Florida.

American Society of Anesthesiologists, Inc., Oct. 22-27, Statler Hilton, Los Angeles, California.

American Society of Clinical Hypnosis, Oct. 25-29, St. Louis, Missouri.

American Medical Association, Clinical Meeting, Nov. 27-30, Denver, Colorado.

COMMUNICATIONS

Michigan State Medical Society
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Dear Sirs:

Just a short note to express my appreciation for your frequent legislative reports during the 1961 session of the legislature.

It is obvious that the busy physician does not have time to keep himself well informed concerning the numerous bills and proposals that are presented to the legislature which directly or indirectly concern the medical profession.

I have found your reports to be very instructive and have been stimulated to express my opinion concerning these matters to our representatives.

Keep up the good work.

Sincerely,
J. M. COLVILLE, M.D.

Detroit, Michigan
June 29, 1961

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In Memoriam

RUSSELL W. ALLES, M.D., sixty-five, Detroit physician, died June 11, 1961.

He was a member of the Wayne County Medical Society since 1924 and a Fellow of the American College of Surgeons.

JOHN D. MOSSMAN, M.D., forty-six, Detroit physician for fourteen years, died June 4, 1961.

Doctor Mossman was a graduate of the University of Western Ontario Medical School. He was on the staffs of Grace, Sinai and Detroit Memorial hospitals. He was a World War II veteran. Memberships included Maimonides Medical Society, Temple Israel, B'nai B'rith, and Keidan Lodge.

DONALD G. ROSS, M.D., sixty-one, Grosse Pointe physician, died June 16, 1961.

A native Detroiter, Doctor Ross was a member of the American Academy of General Practice, and the Academy of Psychosomatic Medicine.

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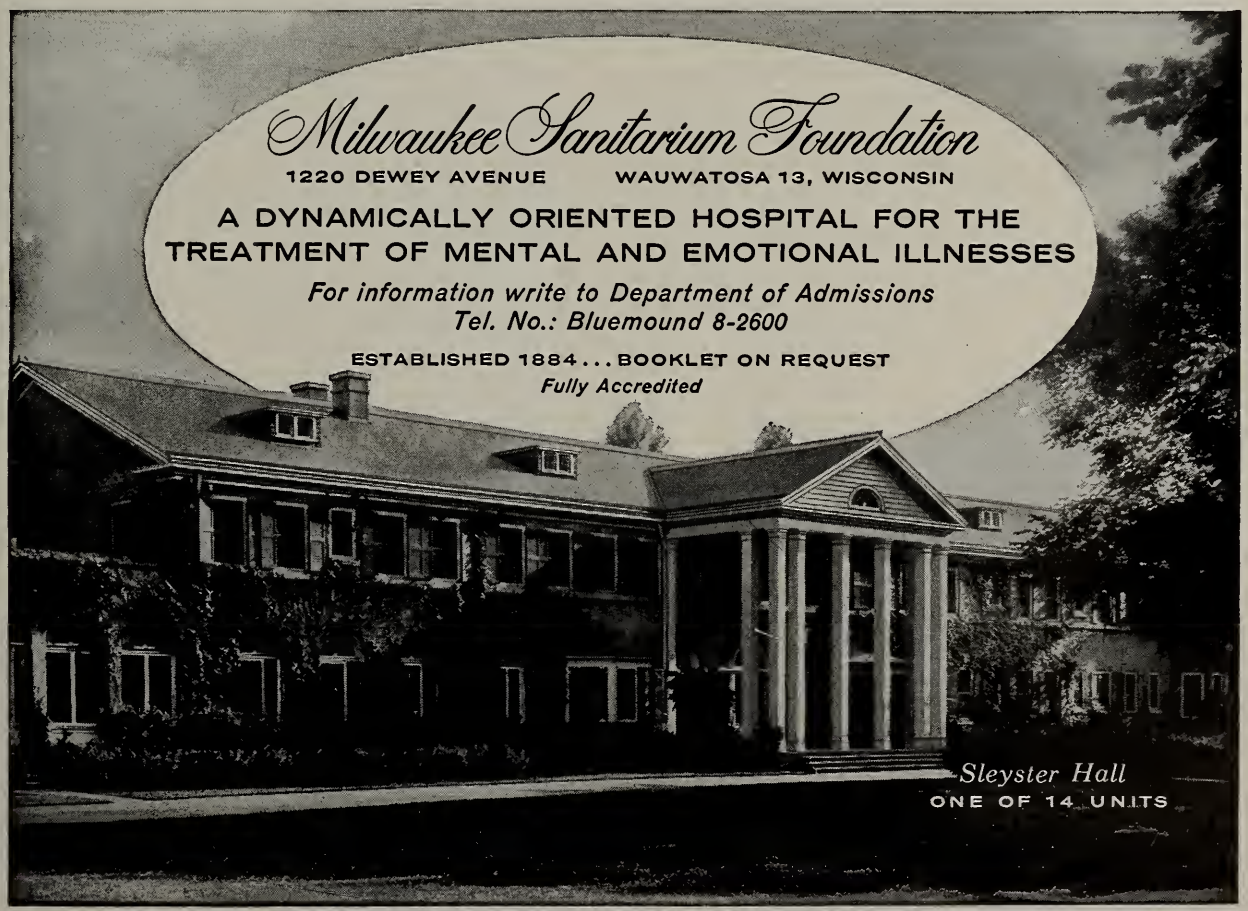
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Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

CHILDBIRTH WITH HYPNOSIS. By William S. Kroger, M.D. Edited by Jules Steinberg. Garden City, New York: Doubleday & Company, Inc., 1961. Price, $3.95.

This book is the first authoritative introduction to one of the newest advances in obstetrics. It contains a scientific and realistic approach to hypnosis and dispels the mysticism so often associated with it. Primarily, it discusses the background, technique and advantages of using hypnosis in childbirth as well as hypnosis in related fields, such as dentistry and general medicine.

This volume is very interesting reading and is of definite value to the physician who is in active practice.

J. R. P.

THE GOLDEN AGE COOKBOOK. By Phyllis MacDonald. Drawings by Margot Tomes. Garden City, New York: Doubleday & Company, Inc., 1961. Price, $2.95.

A book of menu planning and inexpensive, tasty and nourishing recipes, geared especially for those "over 65." Most of the recipes are planned for two servings, while taking into consideration possible limitations of budget, space, equipment and energy. Each season of the year has special menus suggested, and recipes to match. This should be a lift for helping the person used to cooking for many, and now faced with small preparations.

CONGENITAL MALFORMATIONS, CIBA FOUNDATION SYMPOSIUM. Editors for Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Cecilia M. O'Connor, B.Sc. 91 illustrations. Boston: Little, Brown and Company, 1960. Price, $9.00.

This is a Ciba Foundation sponsored symposium containing the papers and discussion of a number of authorities concerned with research on the causes of teratogenesis. It is believed that better understanding of this subject may aid in eliminating many avoidable congenital defects.

The book follows the format of other symposia sponsored by this Foundation, containing the original papers, each followed with a general discussion. It is recommended for those pathologists and geneticists interested in the subject.

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W. B. Saunders Company features the following recent books in their full-page advertisement appearing elsewhere in this issue:

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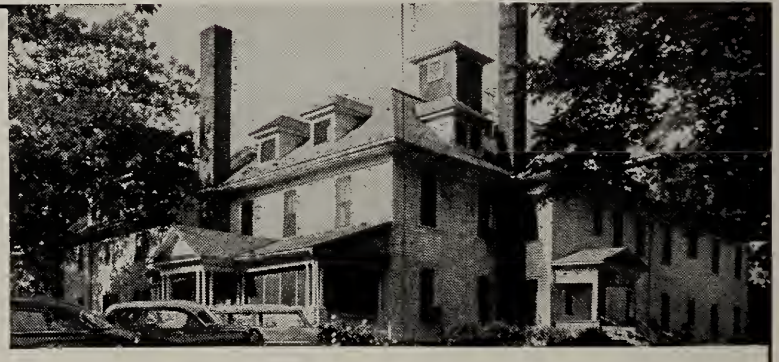
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Hyoscine hydrobromide	0.0065 mg.	0.0195 mg.
Phenobarbital	(¼ gr.) 16.2 mg.	(¾ gr.) 48.6 mg.

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natural belladonna alkaloids with phenobarbital

Prescribed by more physicians than any other antispasmodic

A. H. ROBINS CO., INC.
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Making today's medicines with integrity...
seeking tomorrow's with persistence

President's Page

LET US STAND TOGETHER



Kenneth H. Huson

President
Michigan State Medical Society

This will be my last President's Page—

Next year you will have the privilege of hearing from Dr. Otto K. Engelke of Ann Arbor, who has earned the right to your unqualified support. I wish him the very best.

This year has been for me a most significant highlight of my professional career. It has not been easy, neither has it been boring. I wish that each of you might have had the opportunity I have had to meet and know the members of this great Society, and those in direct relationship to it. You would be proud as am I.

My final plea as I step down is this: may we always give of our very best to the people we serve as physicians; may we also give our very best to those who are so intimately a part of our lives, our fellow Doctors of Medicine.

Let us stand together behind the ideals which we have accepted as our individual responsibility. This is our strength, and through this strength will come the satisfaction of a job well done, for each of us and for all of us of the Michigan Society.

My sincere thanks and deep appreciation goes to each member for the good work done this year.



"County-State" Programs Held Across State

The result of the "County-State Society Night Programs" has been gratifying, reports Kenneth H. Johnson, M.D., MSMS President. Last fall, Doctor Johnson wrote to each of the component county medical societies suggesting that they consider such a project. Quite a number responded.

The idea for "County-State Society Nights" came from the 1960 House of Delegates meeting in Detroit. The MSMS Council, in its recommendations, suggested that component societies be encouraged to sponsor "County-State Society Nights" once per annum, to augment communications and to present information on vital matters to the full membership of the county units. The House concurred.

Dr. Johnson sought requests from interested component societies to invite officials and staff members to county meetings.

* * *

MOST RECENT of such reports was given at the 66th annual meeting of the Upper Peninsula Medical Society at Menominee in June. Doctor Johnson gave a report on MSMS as part of the UP meeting.

Another summer meeting was the Van Buren County Medical Society meeting at Paw Paw. H. J. Meier, M.D., chairman of The MSMS Council, and Lester P. Dodd, MSMS legal counsel, presented the program.

An interesting event was the meeting at Big Rapids recently when the Mecosta-Osceola-Lake Medical Society not only observed its "County-State Society Night" but also invited members of the other professions. Hugh W. Brenneman, MSMS public relations counsel, spoke.

* * *

SEVERAL PROGRAMS were held in the spring. Genesee County Medical Society presented a program at Flint with Doctor Meier and Wm. J. Burns, executive director, as the speakers. The county societies of Huron, Lapeer, Sanilac and St. Clair co-sponsored a meeting at Lexington with President Johnson as the speaker. The Jackson County Medical Society spotlighted President Johnson and Mr. Brenneman.

Other programs since the first of the year have included appearances by Frederick C. Swartz, M.D., Lansing, and Mr. Brenneman at the Bay-Arenac-Iosco society; and Mr. Brenneman also at the Muskegon County Medical Society. Another was the presentation by Doctor Meier at Gaylord to the North Central Society.

HIGHLIGHTS of The Council

Meeting of July 13-14, 1961

Following afternoon and evening meetings of the four Standing Committees of The Council (Advisory Committee to the Executive Director, County Societies Committee, Finance Committee, and Publication Committee), The Council met for two days and discussed 81 items. Chief in importance were:

- Employment of an MSMS Economist. The report of the ad hoc Committee on Financial Possibilities of Implementing Medical Care Study Committee's recommendation to employ an MSMS Economist was given study. The Council took action to retain economic consultants to continue evaluating the McNerney Report; these consultants will work under the direction of a special committee appointed by the Chairman until the House of Delegates meets; an interim fund of $3,000 was appropriated. Chairman of the Interim Committee is H. F. Falls, M.D., of Ann Arbor.
- Policy re podiatry. The American Medical Association House of Delegates, in June, 1961, approved a policy statement on podiatry which had been submitted by the American College of Orthopaedic Surgeons. This AMA statement has been sent to the two Michigan orthopaedic groups for their review and comment; it subsequently will be presented to The Council for approval and referral to the MSMS House of Delegates as the MSMS Statement of Policy re Podiatry.
- Nominations for members of Michigan State Board of Registration in Medicine. Pursuant to statute, MSMS submitted 25 names to the Secretary of State (with copy to the Governor) for five State Board vacancies as of September 30, 1961.
- Wm. A. Hyland, M.D., Grand Rapids, Chairman of the MSMS Delegates to the AMA House of Delegates, presented brief report on actions taken by the AMA at its June, 1961 meeting in New York City.
- Annual Report of Relative Value Study Committee was presented by Chairman Luther R. Leader, M.D. and Vice-Chairman A. Jackson Day, M.D., both of Detroit. The Council received this report with high commendation and referred it to the House of Delegates; The Council also authorized that copies of this report and the Relative Value Study book be sent to each member of the House of Delegates and to Alternate Delegates.
- Committee Reports. The following were considered: Standing Committees of The Council; (1) Advisory Committee to the Executive Director, (2) County Societies Committee, (3) Finance Committee, (4) Publication Committee—all having met July 12; Diabetes Control, meeting of June 7; Disaster Medical Care, June 7; Medical Care Insurance Committee, June 7; Child Welfare Committee, June 14; Liaison Committee with State Bar of Michigan and with Representatives of Michigan Hospital Association, June 14; Legal Affairs Committee, June 14; Medical Care Study Committee, June 18; Geriatrics Committee, June 20; Education Liaison Committee, June 22; Postgraduate Medical Education Committee, June 29; Ad hoc Committee (of The Council) to Expedite Council Meetings, July 13; also considered were the minutes of the Michigan Cancer Coordinating Committee, meeting of May 25.
- Councilor Conferences. Chairman H. J. Meier, M.D., reminded that these Conferences are to be held in advance of the House of Delegates Annual Session.
- Meeting with Governor John B. Swainson. The Governor expressed his greetings to The Council and commented on the health goals to which he and the medical profession aspire. The Council Chairman thanked the Governor for his attendance and remarks.
- The Annual Report of Michigan Medical Service was presented by President G. Thomas McKean, M.D., of Detroit (this is to appear in the Handbook for Delegates).
- Report on the new MSMS headquarters was presented by President K. H. Johnson, M.D., of Lansing, local representative of the Big Look Committee.
- Otto O. Beck, M.D., of Birmingham, President of the Beaumont Memorial Foundation, reported on the Memorial's new furnishings, including 2 tioramas, and a bas relief of Doctor Beaumont created by Marshall Fredericks and contributed by Oakland County physicians. Dr. Beck displayed the new booklet, "Beaumont and the Mackinac Island Miracle" now available for sale both in the Memorial and from the Foundation at fifty cents per copy. A letter of thanks to feature writer Robert Lubbeck of the Detroit News, thanking him for the splendid article on the new booklet which appeared in the Sunday, July 9 News, was authorized.
- President-Elect Otto K. Engelke, M.D., reported on content of statement he will present at the Con-

gressional Hearing on the King-Anderson Bill in Washington on July 27.

- Policy re committee voting. The Council decided the policy that voting members of MSMS Committees must be members of the Michigan State Medical Society.
- Secretary D. Bruce Wiley, M.D., of Utica, reported he had written the Michigan Crippled Children Commission asking that it eliminate the provision of 10 days' after-care as part of surgical fees which now prevails and instead that the Commission follow the Uniform Fee Schedule for Governmental Welfare Agencies to the extent that it allow a daily after-call starting the first day after surgery.
- The Secretary's Monthly Report was approved including use of the MSMS Secretary's Letter to publicize the Michigan Heart Association's Wet Clinics which have been in operation some three years.
- Speaker J. J. Lightbody, M.D., of Detroit, reported on innovations that would make the 1961 House of Delegates' Session in Grand Rapids more efficient, including request to all Delegates to submit resolutions prior to September 1 so they may be placed in the Delegates' Handbook.
- The annual joint meeting between the MSMS Council and the Michigan Crippled Children Commission was held with reports on the Commission's activities being made by Chairman Martin Fleming, Clifford Brainard, M.D., Hospital Field Representative, Clifford Benson, M.D., of Detroit, member of MCCC Medical Advisory Committee, and Carleton Dean, M.D., Director of MCCC. Report was made that 159 hospitals are now approved for afflicted child care and 58 hospitals for crippled child care. Other representatives of the Commission present besides Chairman Fleming were Member Mrs. Freda Engbloom of Iron Mountain, and Advisory Committee Member R. E. Fisher, M.D., Battle Creek.
- Welfare contract. Councilor J. J. Coury, M.D., of Port Huron, reported that the St. Clair Medical Society successfully had negotiated a new welfare contract with the County Welfare Board, which, by using an escalator plan for three years, will reach in 1964 the Uniform Fee Schedule for Governmental Welfare Agencies.
- Legal Counsel Lester P. Dodd of Detroit rendered opinion on propriety of a physician furnishing a report to an insurance carrier without the consent of the injured person who was an employee subject to Workmen's Compensation Act; opinion re bequests of parts of the human body made by a person prior to his death; opinion on granting or withholding of hospital staff privileges; opinion re legal implications of photographing patients presented at scientific meetings; opinion re mediation committee of a component society acting on a complaint which is at issue in actual litigation; opinion on use of a congenital malformed fetus as a laboratory or research specimen, without consent of natural mother.
- Maternal Health case studies. The Council commended the MSMS Maternal Health Committee for developing these case studies, The Council believing that this material is good and valuable for educational purposes.
- Public Relations Counsel's report included up-to-date information on state and federal legislation; a Career Day held July 7-8 at Alma College; and authorization for questionnaire to component societies re information on medical care of the aged as implemented by Kerr-Mills (Federal) and Medical Aid to the Aged (Michigan) legislation.
- Matters of mutual interest were discussed with Michigan Health Commissioner A. E. Heustis, M.D., of Lansing.
- Sir Earle Page, Minister of Health of Australia and former Prime Minister of that Country, outlined to The Council the development and present status of the Australian Health Care Plan. Sir Earle, author of a book entitled "What Price Medical Care?", answered questions asked by members of The Council.
- Annual Report of The Council was submitted, amended in minor areas, and approved for reference to the House of Delegates. A resumé of the Annual Report of The Council is to be printed and mailed to all MSMS members as the "Annual Report of the Michigan State Medical Society" together with a résumé of the 1961 House of Delegates' actions, early in October.
- Annual joint meeting with the Board of Michigan Hospital Association was held and matters of mutual interest were discussed.
- The annual joint meeting with the Michigan Health Council Board also was held, with progress reports and problems discussed generally.
- Appointments: C. P. Anderson, M.D., Detroit, Chairman of the MSMS Disaster Medical Committee, was appointed to represent MSMS at the AMA Conference on Disaster Medical Care, November 4-5 in Chicago; R. W. Teed, M.D., of Ann Arbor, and staff personnel were authorized to attend the AMA Institute (formerly the Public Relations Institute) in Chicago, August 31-September 1.

 Executive Director Wm. J. Burns was authorized to attend the American Society of Association Executives' annual meeting in Denver to receive the "Certified Association Executive" Award which is being presented for the first time to some 35

association executives in the United States; R. L. Rapport, M.D., of Flint, was authorized to attend the Tuberculosis Conference in Chicago on October 11, a meeting sponsored jointly by the AMA, and the TB Associations.

H. F. Falls, M.D., Ann Arbor, was appointed as MSMS representative to the Governor's Commission on Study of Hospital and Medical Economics in Michigan, with Otto K. Engelke, M.D., of Ann Arbor, as alternate.

- H. J. Meier, M.D., of Coldwater, Chairman of The Council, announced his intention to resign as of the last meeting of the 1961 MSMS House of Delegates (Tuesday, September 26, 1961), which decision was received with regret by all members of The Council.

Doctor LeFevre Honored

The Michigan State Pharmaceutical Association at its recent annual convention, presented a "Distinguished Service Award" to William M. LeFevre, M.D., Muskegon, past president of the Michigan Association of the Professions. The award recognized Dr. LeFevre for his outstanding efforts in promoting the professions through MAP, and for his contributions "to the advancement of health education, health organization, and research and progress in pharmacy, and allied professional fields."



W. M. LeFevre, M.D.

Register Now to Attend U-M Doctors' Day

The third annual Doctors' Day Program at the University of Michigan Medical Center, Ann Arbor, Michigan, will be held on Friday and Saturday, October 20 and 21.

The program this year includes a drug seminar, a section on selected problems in trauma, and a medical-surgical grand rounds session at which time several interesting cases will be presented and discussed. This program coincides with the Homecoming activities of the University of Michigan and will be concluded by the Michigan-Purdue Football game on Saturday, October 21. An interesting program for the wives has been outlined.

To facilitate matters, doctors are asked to register in advance with the University of Michigan Extension Service.

AMAS to Meet

The American Medical Assistants Society will hold its fifth annual meeting October 13-15 at Reno, Nevada. John W. Rice, M.D., Jackson, is chairman of the AMAS national advisory committee.

Blues to Confer

National Association of Blue Shield Plans will meet at the Drake Hotel in Chicago, October 23-24. More than 400 delegates will be in attendance, including state and local medical society officers and secretaries, as well as physician-trustees and executives of Blue Shield Plans. Leonard W. Larson, M.D., President of the American Medical Association, will be the featured speaker.

MICHIGAN MEDICAL MEETINGS AND CLINIC DAYS

1961		
September 24-25-26	MSMS House of Delegates	Pantlind Hotel, Grand Rapids
September 27-28-29	MSMS Annual Scientific Session	Pantlind Hotel and Civic Auditorium, Grand Rapids
September 27-28	Michigan State Medical Assistants Society	Occidental Hotel, Muskegon
September 27-28	Woman's Auxiliary to MSMS	Pantlind Hotel, Grand Rapids
October 19	Calhoun County Clinic Day	Battle Creek
October 20-21	U-M Doctors' Day	Ann Arbor
October 25	Bronson Hospital Clinic	Kalamazoo
November 7-8-9	Annual Fall Postgraduate Clinic	Detroit
December 6	Annual Symposium on Trauma	Detroit
1962		
February 28-March 1-2	Michigan Clinical Institute	Detroit

Weekly Radio Series To Serve Physicians

Detroit radio station WDTM is presenting each Tuesday a "Medical News Service" expressly for physicians in the Detroit metropolitan area. Produced in cooperation with the Detroit office of the Michigan State Medical Society, the program is aired each Tuesday between 12 noon and 3:05 p.m.

Following WDTM's noon newscast, announcements of the coming week's medical meetings and events are broadcast. A 90-minute interpretive medical feature is presented at 12:30 p.m. At 1 p.m., current medical news of interest to physicians is offered in a five-minute report prepared by the Michigan State Medical Society.

The 2 p.m. feature is a medical abstract, selected for broadcast by the Michigan State Medical Society. At 2:30 p.m. another interpretive medical feature is presented, and following the 3 p.m. news, the Medical News Service features an interview by Dan Price, WDTM editorial consultant and radio personality, long a favorite with Detroit listeners. The interview with an M.D., or a competent lay authority, is concerned with pertinent medical developments.

Both WDTM and MSMS will welcome comments and/or suggestions concerning this specialized news service.

Communication Potentialities Of the Printed Word

By JEAN WORTH, Editor, *Escanaba Daily Press*

(Last of three installments of a paper presented before the 1961 MSMS County Secretaries-Public Relations Seminar. The first part of the paper appeared in the June issue and the second part in the August number)

It is said that to a mouse, cheese is cheese; and that that's why mousetraps work—but humans shouldn't be mousetrapped!

What are the American public's "identification reactions to the word medicine?" Do some of them include:

> Patent medicine . . . A drink of Old Grandad . . . Punishment . . . The top of the prospect list at the Cadillac agency . . . Scientific medicine . . . The doctor's lobby . . . Grandma's last chance . . . Opposition to the United Auto Workers' health care plan . . . The company should pay for health insurance . . . Autopsy on the Forand Bill . . . The best humanist expression of scientific advancement . . . Medical profession economic conservatism in collision with militant political socialism.

The doctor's reaction to the word obviously is different than that of the politician (unless he's ill), the patient, the welfare administrator, the octogenarian, the collegian, the bride of a year.

The doctor knows this, of course. You've got to be highly intelligent to get through a medical school, but it is notable that the same doctors who have been so impressed by the increased incidence

of psychosomatic illness haven't noted the prevalence of psychosomatic public opinion.

Like our other scientists, the physician has been so intensely occupied by the play that he has neglected the theater. He cannot be fully effective this way. His patient does not live in a vacuum. He, too, is a citizen.

Even when the doctor uses all means of communication, the printed word, the radio word, the television picture and word, it will be difficult enough for him to make the knowledge of his profession meaningful to the public. The complexity becomes more difficult to explain and the audience becomes more distracted by competitive interests and particularly by diversions.

When the scientist feels no obligation to explain his science the public is even more apt to err in policy because other partisans have their say with less effective opposition.

* * *

Students of advertising are taught that, psychologically, the end of man is action. Even if man is an encyclopedia, he's a walking encyclopedia and the information that he has should tell him where to go and how to get there. This is the function of the printed word.

But to attribute to cold type the power to inspire is absurd.

The power of words is appeal to human nature. To exercise any power they must be read and acted upon. The power of the printed word rests on the nature of man. He reacts to any stimulation.

It has been said that on the printed word depends our entire system of education, government, law and religion; that we have no substitute for the permanent values inherent in the printed word.

Whether or not this is true, it is obvious that we are in a reading habit unparalleled in any era. Our reading public has grown even faster than our population and this leads us to great expectations, but we must be mindful that reaction to reading, and not the mere action of reading itself, is what is important.

When I left breakfast for work one morning recently, my wife was watching our Senator McNamara and a representative of the AMA speak on medical care for the aged on TV. At noon, I asked her impression of the program and she thought that McNamara had come off pretty well. This is revealing.

The medical profession has created an extra age for the elderly by medical advances. Are the authors of this extension of the life span now to be elbowed aside by the politicians as unfit to care for the patients they have saved?

What is medical care for the aged semantically?

Is it a politician's perpetuation in office until death of old age?

Or is it a huge step into socialized economics? Senator McNamara sounded good on TV because humanity is a fine sermon topic forever, and economics are serious, complex and repellent. Who wants to be reminded of the burden of medical care under social security? Persons entering security coverage now could get a better pension for their money from an insurance company—if they had a choice.

Arthur Mitchell, the U. S. commissioner of social security, was in our town last summer and I had a bottle of beer with him and the manager of our district social security office. To the local manager, social security is a sort of religion and save-all. But Old Pro Mr. Mitchell has no mystic feeling about it. "All we do," he said, "is to take the money you send to Washington and give it back to you, less a certain amount for administration." This was almost heresy to the local manager. It spoiled his beer.

These are the semantics of medical care for the aged.

Cheese is cheese, but medical care for the aged is different. Doctors shouldn't be mousetrapped by it in public opinion. The way to avoid it is for all of them to regard public education as an inseparable obligation of medical practice in a democracy. This is a two-way street. The necessity for explanation often influences policy.

The public reaction to the printed word from the medical profession will be strongly influenced by the "identification reaction" to our doctors. This is a "who done it" of enormous importance to America's future.

The medical profession has achieved wonderfully well for Americans in medical science.

It has not done nearly as well in medical education of the public.

Hence its public image is not as great as its true stature.

For the profession, this may be only regrettable, but for the public, it can be tragic. The hope for improvement must rest heavily upon the medical profession.

Course Developed

The Board of Trustees of the American Medical Association has endorsed a joint project with the University of Chicago to prepare and present a home study course entitled *"Legal Problems in the Practice of Medicine."* The AMA looks on this course as a means of providing the physician with an opportunity to acquire some knowledge of the principles and operation of American law as well as the interrelationships of law and medicine. Information may be obtained from the University of Chicago Home-Study Department, 60th at Dorchester, Chicago 37, Illinois.

Need for Committees Cited by Jay C. Ketchum

"The most influence on overuse and abuse of prepayment and insurance plans can be achieved by an intelligent, alert, organized profession."

That statement was made recently at a national meeting by Jay C. Ketchum, executive vice-president of Health Service, Inc., and of Medical Indemnity of America. He formerly was executive vice-president of Michigan Blue Shield.

He said, "The public, represented by employers, labor organizations, and supervisory authorities, is investigating, surveying and debating the operation, the policies, the attitudes and controls of Blue Cross plans.

"The charges (of overutilization and high cost) must be answered and it must be demonstrated effectively that the doctors, hospitals and plans are concerned and are doing something constructive about it."

For this, the organized committees are a necessity, he said. Freedom of choice in medical care can be maintained only by acceptance of responsibility in voluntary prepayment by all the interested parties —hospitals, medicine, the public, the plans, he warned.

In addition to the in-hospital committees, similar bodies "under a variety of names and organizational schemes, are being set up and operated by medical societies for professional relations with prepayment and insurance plans," Mr. Ketchum said.

* * *

Report on Free Care

Physicians in 48 states and the District of Columbia provided free medical care worth $657,535,000 in 1960, a survey by *New Medical Materia* shows.

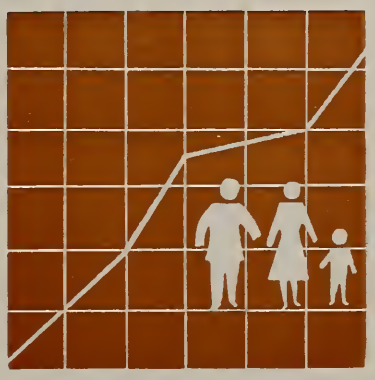
The total is 10.6 per cent more than the $594,903,000 worth of medical care provided free by physicians in 1955. As *New Medical Materia* points out, the services were given "without compulsion or expectation of public applause."

The magazine's survey showed that Michigan physicians gave $21,259,000 in free care last year.

* * *

Michigan Home-Care Trial Continued

Michigan Blue Cross has announced that early results of a pilot program to provide Blue Cross benefits for home care are favorable, and that the program will be continued through 1961. The pilot study, approved by the State Insurance Commissioner, was begun in February, 1960, in cooperation with four Detroit hospitals, the local Blue Cross Plan and the existing home care program of the Detroit Visiting Nurse Association. Its purpose was to determine whether hospital stay could be significantly reduced for certain patients, and if recovery might actually be faster for these patients in home surroundings.



Under the program, Blue Cross pays the cost of visits by VNA nurses, physical therapists and social workers, plus drugs and dressings. It also pays half the cost of VNA home aide service when needed.

Participation in the program is entirely voluntary; patients are referred for home care by their physicians.

Results of the study to date indicate that only about 2 per cent of hospital cases qualify medically for home care, but that there are significant advantages for those who do. During the first 11 months of the program, 416 cases received home care services. *The attending physicians estimated that some 19 days of hospital care per case were avoided.* The cost per patient day of home care averaged about $3.75 in contrast to a per day average hospital cost of $35. The sponsors point out that beds vacated by home care patients were usually promptly filled by other patients needing hospital care—about two-thirds of whom were Blue Cross members. However, the consensus is that in this limited program, home care has more than paid for itself.

Some two-fifths of the patients treated were between 45 and 65; 37 per cent were over 65, and 24 per cent under 45. Cancer, heart and circulatory cases, diabetes and fractures were found to be the types of cases most suitable for home care.—*AMA Chronic Illness News Letter,* June, 1961.

* * *

Blue Shield-Blue Cross Proposes Broader Plan on Small Scale

Michigan Blue Cross-Blue Shield soon will offer a new "Broad-Spectrum" Supplemental Health Care Program on a limited basis. Approved by Frank Blackford, Commissioner of Insurance, the new program is designed to reduce additional out-of-pocket expenses not now covered in the traditional basic health care program.

The optional program includes, on a share-the-cost basis, such items as home-and-office calls, prescribed drugs, private duty nursing, out-of-hospital psychiatric care, and ambulance service.

For the working Michigan family making $7,500 or less and enrolled in the basic comprehensive Blue Cross-Blue Shield M-75 plan, the cost is about 10 per cent more than the current rate for the basic program. Total rates will vary according to family and income status, but the new program will be available to everyone in a group.

For the additional 10 per cent in cost, subscribers will receive up to a maximum of $50,000 worth of additional and extended health care benefits.

The new Blue Cross-Blue Shield pilot program will work like this:

1. Full service will continue on the basic Blue Cross-Blue Shield Comprehensive M-75 program, but will be extended up to a maximum of $30,000 worth of needed additional hospital days. The limit of the current basic contract is 120 days.

2. Supplemental benefits such as private duty nursing, home-and-office calls, prescribed drugs, out-of hospital psychiatric care, artificial limbs, and ambulance service will be provided on a cooperative basis.

Example: Subscribers will pay 20 per cent of the cost of such health care expenses as drugs, home-and-office calls, and ambulance. They will pay 50 per cent of the cost of private duty nursing and psychiatric care.

To keep down the cost of the program, there will be a "corridor of expense" borne directly by the subscriber before he or a member of his family can take advantage of the additional benefits. For example, a family with an income of less than $7,500 will pay $150 deductible, and an individual will pay only $100 before additional benefits become available.

After paying the deductible amount, a subscriber then becomes eligible for up to $20,000 in additional benefits. The total maximum extended and additional benefits could reach as much as $50,000.

Sumner Whittier, executive director of Blue Shield, has commented: "Under our new program, a physician will be reimbursed according to our regular set fee schedule as before, but in addition, the patient will be able to budget for the home and office calls that are often required in connection with service."

* * *

Pharmaceutical Research

A record $206.5 million investment in research was made last year by drug manufacturers in the search of new cures for human ailments. The new high was reached despite a general down-turn in profits, according to the annual survey on research and development released by the Pharmaceutical Manufacturers Association.

The 1959 figure was $197 million.

Research expenditures this year will rise to about $227 million for human drugs, the trade association reported.

* * *

Blue Shield Enrollment

Enrollment in the 75 Blue Shield Plans serving North America was 47,953,005 at the end of the first three months of 1961, representing an enrollment of one out of every four Americans, and nearly 15 per cent of the total Canadian population.

The national association also reported that 14 Blue Shield Plans have enrolled more than 40 per cent of the population in the areas they serve.

Tumors of the Nose and Nasal Accessory Sinuses

James E. Croushore, M.D.
Detroit, Michigan

THE ANATOMIC PROXIMITY and the similar mucous membrane lining of the nose and sinuses, requires them to be considered jointly when discussing cysts and tumors of these areas. Tumors occurring in this vicinity include almost every type of tumor found elsewhere in the body. Some tumors, however, occur only in these areas.

Cysts are either congenital, because of imperfect intra-uterine fusion of the nasal structures, or acquired as a result of chronic inflammation. Developmental cysts of the maxilla may originate from odontogenic tissue or non-dental tissue. The commonest benign external tumors in this area are lipomas, fibromas, dermoid cysts, and senile warts. Gliomas, meningoceles, and hemangiomas may have a similar gross appearance and caution must be exercised in biopsy or excision.

Epitheliomas, pre-cancerous lesions, and basal cell epitheliomas are usually readily visible and, in early stages, offer a good prognosis.

The most common benign tumor is the inflammatory or allergic polyp. The antrochoanal polyp, at times, grows to large, deforming proportions, and may recur unless removed by the Caldwell-Luc approach. Nasopharyngeal fibromas, or so-called juvenile basal fibromas, are very vascular and occur chiefly in adolescent males. The true papillomata of the nose occur most frequently in the septum and turbinates.

Squamous cell epithelioma is the most common malignant tumor of the nose and sinuses, with the glandular of adenocarcinoma ranking second. Geschickter,[1] in reporting 211 tumors of the paranasal cavities, gives a concise description of their clinical and microscopic characteristics. He also classifies them into four main groups: benign epithelial tumors, malignant epithelial tumors, benign connective-tissue tumors (exclusive of 76 osteomas), and sarcomas.

Most tumors of the nose and sinuses, unfortunately, are not discovered until they are well advanced. Symptoms do not appear early. The common exception is repeated epistaxis in the vascular and ulcerated lesions. X-ray seldom reveals the true extent of the invasion of the growth, and each individual case requires the accumulation of much data for adequate evaluation of the patient.



From the Department of Otolaryngology, Wayne State University College of Medicine where Doctor Croushore is Clinical Professor of Otolaryngology.

Management of Tumors

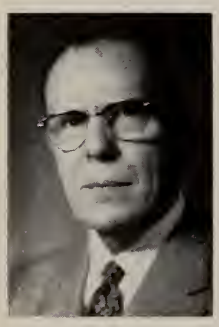
In the management of tumors of the nose and sinuses, one must think of the head and neck inclusively, since these tumors so often extend beyond their original confines. In teaching institutions, the ideal method of managing these cases is on a head and neck service. The personnel of the head and neck service is composed of representatives from medicine, general surgery, otolaryngology, ophthalmology, oral surgery, plastic surgery, neurosurgery, pathology, and x-ray. All tumor cases involving the head and neck should be reviewed by a board composed of designated individuals from each of these departments. Thus, a better over-all evaluation of the patient is obtained.

The advances in preoperative and postoperative care, refinements in surgical technique, drugs used in anesthesia, methods of preventing and combating shock, have made radical cancer surgery relatively safe and have resulted in a higher cure rate. However, mutilating surgery is not indicated unless the probability of a cure is fairly certain. Also, will the patient be happy without the cancer if greatly handicapped by loss of functions, or not presentable in public because of a revolting disfigurement?

X-ray has taken its proper place in the treatment of cancer. Comparative statistics on results obtained from surgery and radiation therapy are unreliable, as no two cases in a series are identical. Sound judgment will dictate whether either or both methods should be employed in any given case.

Surgery, electrosurgery, and irradiation combined may eradicate the growth, where only one method might fail. Electrosurgery is often used advantageously in the control of hemorrhage and sealing off vascular and lymph avenues of metastases.

Chemotherapy, as an adjunct to radiation therapy, has been used for about eighteen years. The value of chemotherapeutic agents is limited by the toxic effect on the hemopoietic system and the gastrointestinal tract. A greater concentration of the alkylating agent can be administered to the tumor by regional perfusion, utilizing an extra-corporeal circuit with the heart-lung machine.[2] At present, perfusion is indicated as an adjunct to standard therapy, treatment of regionally confined but nonresectable tumors, and palliative for advanced cancer.



The Author

JAMES E. CROUSHORE, M.D.

Benign Tumors

Inflammatory Growths or Polyps.—Sometimes referred to as soft papillomas, these growths result from allergy or infection. They may be classed as oedematous, fibrous, angiectatic and glandular or cystic. There is less tendency to recurrence when the primary cause is eliminated.

Epithelial Papillomas (Hard Papillomas).—Not as common as polyps, epithelial papillomas usually have their origin on the septum or turbinates. Verner and his associates[3] reported ten cases of epithelial papilloma and were unable to arrive at a definite cause for their occurrence. These growths have a marked tendency to recur unless removed by electrocautery. Occasionally carcinomas of the nose show a papillary structure, indicating a probable origin in hard papillomas (Fig. 1). Truckey[4] holds the opinion that radical surgery is, at times, necessary to prevent recurrence and especially when they may become carcinomatous.

Appendage-Cell Tumors.—These may either be benign or malignant, depending on their cellular origin. They may remain benign many years and then assume malignant characteristics (Figs. 2 and 3). The benign tumors are the aberrant salivary and cystadenomas. Their occurrence in the sinuses is usually due to invasion from adjoining structures, most commonly the hard palate.

Benign Connective-Tissue Tumors.—These are usually represented by angiomas, plasmocytomas, fibromas and osteomas. Angiomas are difficult to distinguish from the angiectatic polyp. They are soft, red and bleed profusely. They are best treated by electrocoagulation and irradiation. Woodson[5] described a method of removing a nasal hemangiopericytoma. This tumor is characterized by cells in clusters outside the lumen of the blood vessels. This was a large, vascular tumor filling the nasopharynx and having its origin in the middle meatus. At operation, the external carotid was first ligated. A nasal snare was placed over the nasopharyngeal extension and the snare wire then pulled forward into the naris by a tonsil hook introduced anteriorly into the nose. The pedicle was snared off and the middle meatus immediately packed. X-ray treatment was started immediately, giving 3000

roentgen units. There was no recurrence after four years.

Plasmocytomas may be either benign or malignant. Great numbers of plasma cells are grouped together and are sometimes similar to granulomas. Fibromas and osteomas present no difficult problems in treatment, unless permitted to grow to destructive and locally invasive proportions.

Malignant Tumors

Squamous Cell Carcinoma comprises the bulk of malignant growths of the nose and sinuses. These tumors, sometimes designated as transitional-cell, invade adjoining structures and involve regional lymph

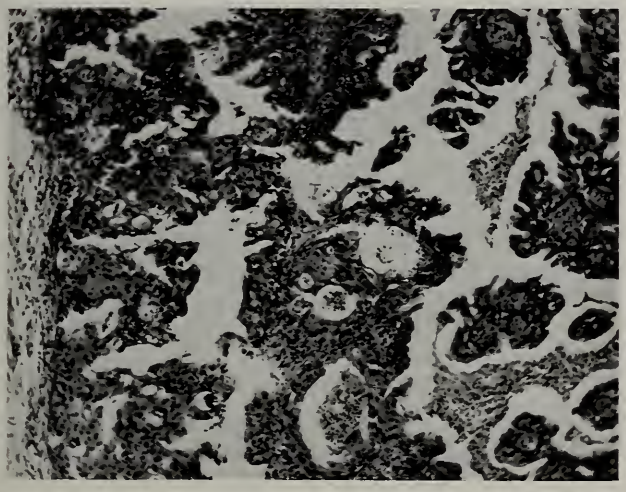


Fig. 1. Poorly differentiated papillary carcinoma of nose. Note gland formation and papillary projection lined by anaplastic cells. H & E (×65). Initial symptom in an eighty-three-year-old woman was epistaxis.

nodes. The transitional-cell tumors or lymphoepithelioma are common in the nose, nasopharynx and pharynx where epithelium is intimately associated with lymphoid tissue. The truly transitional-cell tumors refer to a basal-cell type epithelium where there is an imperceptible protoplasmic transition from the basal epithelial cells to the reticulum cells of lymphoid structures. They metastasize to distant areas late in the disease. Those tumors arising high and posterior in the sinuses are manifested late, invade the base of the skull early and the cure rate is extremely low. Those having their origin low and anterior are recognized earlier, do not invade deep structures until late and the prognosis is better. The antrum is most commonly involved, the ethmoids next. The frontals and sphenoids are rarely involved, except by extension from the other sinuses or nose.

Radical surgical removal is about the only hope for cure. X-ray and electrosurgery are frequently used in combination with radical excision. Tabb[6] has analyzed sixty cases of carcinoma of the antrum with special reference to primary surgical extirpation. This analysis clearly indicates the necessity for early diag-

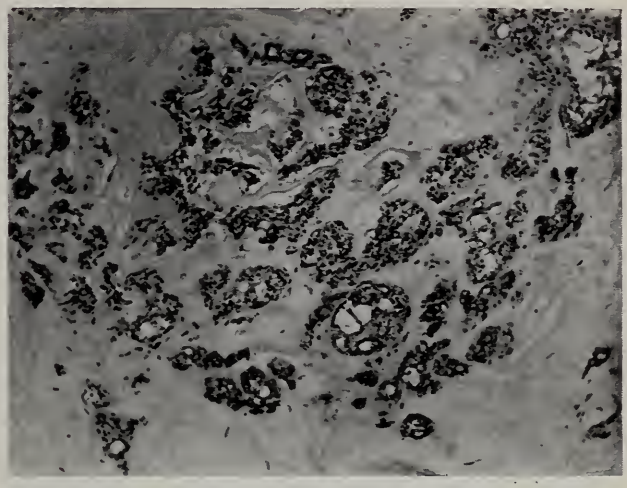


Fig. 2. Mixed salivary gland tumor of hard palate. Benign in 1950. H & E (×65).

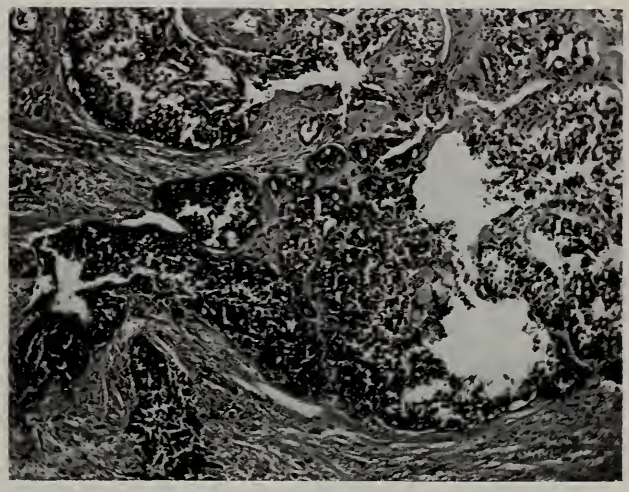


Fig. 3. This is from the same tumor as illustrated in Figure 2. This biopsy, taken four years later, shows recurrent tumor now revealing marked anaplastic appearance and definitely invasive. H & E (×65).

nosis. Frequently, the exact point of origin cannot be determined because of the extent of the tumor when first seen. He is of the impression that distant metastasis is more common than reports indicate. If autopsies were performed on all persons dying from carcinoma of the sinuses, the percentage of metastases would rise far above the present recognized levels. This article is well illustrated and the surgical technique for maxillectomy is explained in detail.

Barbosa[7] has developed a technique for more radical excision of carcinoma of the sinuses. The frequency of recurrence in the orbit prompted him to

extend the surgical field to the orbit more often. In his earlier resections of the upper maxilla, he attempted to preserve the eye. His new technique differs from the standard technique of maxillectomy in the following maneuvers:



Fig. 4. Benign giant cell tumor of the ethmoid. There are accumulations of multi-nucleated giant cells typical of the lesion and inconspicuous fibroplastic elements. Seen in twenty-year-old man. Radical excision by external approach followed by radium insertion. Well after nine years.

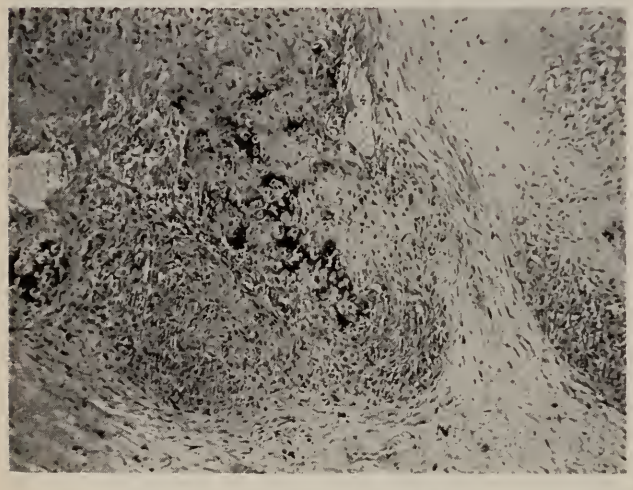


Fig. 5. Osteogenic sarcoma, chondroblastic type. Note lobulated appearance of the tumor with foci of osteoid formation and calcification. H & E (×58). Maxillectomy with incomplete removal because of invasion of base of skull.

1. The skin incision, although similar to the Weber-Ferguson, is slightly more extensive and permits wider exposure.

2. The posterior border of the mandibular ramus is exposed early, the parotid gland retracted posteriorly, thus making accessible the zygomatic fossa for ligation of the internal maxillary artery.

3. The external and superior orbital rim is exposed and the orbital contents elevated subperiosteally. The nasal bone of this side is removed with a small portion of the frontal and maxillary processes.

4. The electrosurgical knife is used freely for cutting soft tissue.

5. The pterygoid process is usually included in the specimen by cutting it at its base, rather than the pterygomaxillary junction.

6. Thorough irrigation of the wound after the surgical specimen is removed. Topical cancericidal drugs are employed at this point.

7. The wound is skin grafted. This is especially necessary to cover dura or defects in dura.

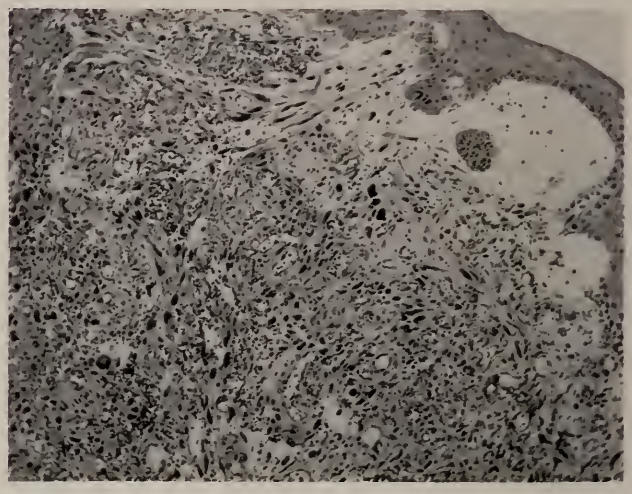


Fig. 6. Rhabdomyosarcoma of posterior tip of inferior turbinate and adjacent floor of nose. Note loose arrangement of the spindle-shaped tumor cells and hyperchromatic nuclei in bizarre forms. The overlying epithelium is intact. H & E (×65). Male, aged eight years. Excised intranasally March 17, 1952. Recurrence and again excised August 31, 1953. Recurrence and excision August 31, 1954. This time, the posterior edge of the septum was involved. Radical intranasal excision has resulted in no recurrence to date.

Barbosa employed this technique in fifty-nine patients. Irradiation was used after surgical resection. Clinical evidence of cervical metastasis was manifest in twenty-one cases and fifteen of these were submitted to radical neck dissection. There were positive nodes in thirteen.

Cylindroma is not only found in the nose and sinuses, but also in the other areas of the upper air and food passages, where adenomatous tissue is abundant. Pathologists generally agree that these tumors originate from mucous glands and are manifested beneath the mucosa of the lips, oral cavity, tongue, palate, pharynx, nose, sinuses, trachea, bronchi, hypopharynx, and esophagus. Saboroff[8] has reported three cylindromas involving the nasal passages, tongue and larynx. His extensive review of the literature indicates a uniform perineural lymphatic invasion by masses of tumor cells. Cylindromas are slow growing, have a great tendency to local recurrence, but wide

excision offers a fair prognosis. However, they are malignant and, if not controlled locally, do result in widespread general metastasis. Russell[9] explained that the chief cause of recurrence of cylindroma was the poor encapsulation.

One would not expect epistaxis to be the first symptom of a nasal tumor of neurogenic origin. However, in one of two cases of schwannoma reported by Johnson and Linebach,[10] nasal hemorrhage was the initial symptom in one. Schwannoma is, at times, difficult to differentiate from neurofibrosarcoma. The clinical progress of the patient may be required to establish a final diagnosis.

Sarcomas, which are tumors of mesodermal origin, occur less frequently than ectodermal tumors. Those of low grade malignancy are giant-cell tumor (Fig. 4), angiosarcoma, and myosarcoma. Medium grade are fibrosarcoma and chondrosarcoma (Fig. 5). The high grade tumors are round-cell sarcoma (reticulosarcoma), lymphosarcoma, rhabdomyosarcoma and Ewing's tumor, which is an endothelioma of bone marrow. Eggston and Wolf[11] state that fibrosarcoma is the most common type of sarcoma found in the nose and nasal accessory sinuses. The sarcomas generally are rapid growing and are radioresistant.

Rhabdomyosarcoma (Fig. 6), an embryonal type tumor, is interesting in that it has many histologic variations that cause doubt and confusion in diagnosis. The characteristic cell is a short spindle cell with a centrally located, elongated nucleus, rich in chromatin. It occurs most frequently in male children. Moore and Grossi,[12] in reporting thirty-seven cases, found the primary site as follows: orbital cavity, including eyelids, eight; soft tissue of neck, seven; nasopharynx, six; cheek, five; mandible, three; palate, three; tonsil, two; gingiva, one; parotid, one; and the external auditory canal, one. The present author has had one patient with the tumor arising on the posterior aspect of the right inferior turbinate.

Comment

Experience in the treatment of benign tumors of the nose and nasal accessory sinuses clearly reveals that surgical excision in the vast majority of cases is the procedure which should be applied. Malignant tumors, because of their individual characteristics, may require a combination of modalities for eradication. The available methods of attack are surgery, electrosurgery, irradiation and chemotherapy.

Many important structures necessary to a comfortable and useful life must be sacrifices in radical surgery of the head and neck. Unless the surgeon is confident the cancer can be permanently eradicated by this sacrificial surgery, more conservative and less debilitating treatment should be humanely employed. Statistics indicate that the disease is usually the winner in the struggle; however, we must continue to try to devise means of reversing this position.

Conclusions

1. Tumors of the nose and especially the sinuses are not manifested early.

2. Earliest manifestations of tumors of the nose are epistaxis and obstruction. Earliest manifestation of tumors of the sinuses is usually swelling. By then, the growth is extensive.

3. The cure rate is highest when diagnosis is established early and treatment instituted immediately.

4. The type of treatment chosen will depend upon the cell structure of the tumor, site of origin, extent of growth, age and physical condition of the patient.

5. Any one or combination of the four available methods of treatment may be employed: surgery, electrosurgery, irradiation or chemotherapy.

6. When treatment fails to cure, death is usually due to local recurrence, rather than distant metastasis.

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Tuning or Pitch Forks

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THE LOWLY TUNING FORK is highly underrated. Introduced in 1711 by Handel's trumpeter, John Shore, as the first accurate pitch standard,[1] it has been better known for its testing and analyzing of hearing losses. Pitch standards have varied from an initial low of 422.5 vibrations per second (vps) for the musical tone *A* to a high of 458 in 1880, and then down to the Philharmonic level of 439—popular since 1896.

Emphasis on important electronic devices in testing hearing has overshadowed the time-honored tuning fork. However, tuning fork vibrations have recently been used to run springless wristwatches. This new application of an old principle prompts further investigation of its clinical value.

Lempert[2] stressed tuning fork tests in determining the amount of cochlear reserve and testing the better ear for AC (air conduction). He observed that a 512 tuning fork is:

Heard the same in both ears when AC is identical and cochlear reserve is similar.

Equally not heard in both ears when cochlear reserve is bad bilaterally and AC is equal or unequal in both ears.

Heard in one ear only when the cochlear function is good only in that ear.

Heard better in the ear with the greater nerve function regardless of whether AC is equal or not.

Heard better in the ear with less AC when the cochlear reserve is equal.

He also emphasized that false-positive bone conduction hearing tests can be discovered by observing involuntary, objective emotional signs. These include: delayed responses when a testing tone is not heard; spontaneous, joyful grin when hearing bone conduction (BC); and sudden change to sad, forlorn look when sound is no longer heard. Speech testing by meaningless words (i.e., trapad, setdug, subnoy, gibzink, ceboo, and parachod) before and after amplification, may help in determining operability.

Tschiassny[3] credits Philippus Ingrassia with the discovery in 1546 of both the stapes and bone conduction. The basic principle of hearing a vibrating tuning fork held against the teeth makes it possible to differentiate perceptive from conductive losses. Weber, in 1825, noticed that in certain deaf people the tuning fork when placed at the skull was better heard in the bad ear, indicating conductive deafness. In 1855, Rinne compared the bone conduction and air conduction of each side separately, and stated that when BC was greater than AC the conductive apparatus was diseased. Shortly thereafter, Bezold proposed the terms "negative" or "positive" for the Rinne test. Confusion persists on the interpretation of this terminology, and it is better to specify AC$>$BC or BC$<$AC. Schwabach published in 1885 his report on comparison of abnormal bone conduction to that of a person who hears normally.

Reger[4] reviewed the methods of testing hearing sensitivity. Before 1920 when the audiometer was developed, auditory tests were done mainly with tuning forks, watch tick, Galton whistle, Koenig rods, monochord, acoumeter, and whispered or spoken voice. Uniformity of testing and standardized sets of forks are desirable.

Sonnenschein[5] carefully analyzed sounds of tuning forks and emphasized the "center of percussion" at the junction of the middle and distal thirds of the fork prongs. Optimum intensity and less overtones result when striking the prongs at this point.

In 1922, Macfarlan[6] began to standardize tuning fork testing. He controlled the amplitude by striking the fork by a measured blow using a pleximeter. The damping factor was determined for each fork and the exact amount of loss of hearing of the patient was measured in sensation units. Better lateralizing of the Weber test was found by using the forehead. By shifting the "butt" of the fork, the exact position can be determined where BC hearing is no longer lateralized.

Pohlman[7] reviewed bone conduction sensitivity and stated that in the sixteenth century Capivaccio distinguished conductive and perceptive losses by comparison of BC and AC. Further, he credited Wheatstone with the observation in 1827 that a vibrating

tuning fork on the vertex of the head was heard better in the ear whose canal was occluded. He believed that proper masking eliminated the supposed increased bone acuity reported for certain conductive losses like otosclerosis.

for conductive, perceptive, and mixed hearing losses were thus shown.

Audiograms were made by Onchi[10] with modified tuning fork tests, using the time difference for a patient and a normal person. This time difference is multi-



Fig. 1. Weber test showing lateralization to the poorer ear in the upper figures as seen in a conductive loss (BC>AC). A perceptive or sensorineural loss is shown in the lower two figures with the Weber test referred to the better ear (AC>BC).

Hearing charts for a series of tuning forks were reviewed by Dundas-Grant.[8] He mentioned Hartmann's pioneering work in this field using the percentage duration of hearing power. Actual hearing power, however, depends on the amplitude of vibration of a tuning fork, which diminishes in geometric rather than arithmetic progression. That is, it does not decrease by equal amounts from second to second.

In 1927, Hallpike[9] introduced a graphic chart to represent auditory fields. He plotted curves for air and bone conduction using tuning forks and duration in seconds compared to normal. Characteristic curves

plied by the damping constant of the tuning fork to find the hearing loss in decibels for that frequency. Measurement of the time difference is done by an acoustical instrument similar to a stethoscope, with one tube going to the subject's ear and the other to that of the examiner.

In 1948, F. Kobrak[11] stated that differences noticed between tuning fork tests and audiometry may be due to the factor of "efficiency." "Period hearing," or the function of hearing a diminishing tone for a certain time, may be more easily detected with tuning forks.

Ballenger[12] declared that tuning forks usually can-

not be heard when there is 50 per cent or more impairment of hearing. He also stated that "the diagnosis of the cause of deafness can often be made more satisfactorily by means of the tuning fork."

of conductive loss, the Rinne may be positive when the loss by air conduction is less than 35 decibels (db).

In testing normal subjects for the Rinne test, Alexander[14] found a reversal phenomenon when using a



Fig. 2. Recruitment can be shown by loudness balance tests. Soft tones are heard in the unaffected ear better (*left figure*). Moderate tones may be heard equally loud while high intensity sounds may actually seem louder in the affected ear.

Harbert[13] prefers the use of a 512 tuning fork because it is heard and not felt as vibrations, as are forks of lower frequency. Higher frequency forks may actually be heard by air conduction when using them for bone conduction.

Common Tuning Fork Tests

One must evaluate the common tuning fork tests to learn how useful they are:

Weber Test.—Weber's test is done by placing the stem of a tuning fork on the forehead or teeth and having the patient state whether the sound is louder in one ear. The sound should be lateralized to the poorer ear if a conductive loss is present, and to the better ear if it is a perceptive loss (Fig. 1). Confusion of lateralization may result from use of forks of different frequency, and if recruitment or resonance factors are present.

Schwabach Test.—This test is a comparison of the duration of the patient's bone conduction to normal.

Rinne Test.—Comparison of the duration of air conduction to bone conduction is done to determine the cochlear reserve. Normally there is a 2:1 ratio with the hearing being twice as long by air as by bone. In conductive hearing losses, this relationship may be equalized or reversed, i.e., BC = AC or BC > AC. In perceptive deafness this ratio is maintained. The Rinne test is said to be positive when AC>BC as in the normal. When BC>AC, then it is a negative Rinne. It is important to test with 512 or 1024 forks to rule out combined hearing losses. In mild degrees tuning fork vibrating very strongly, i.e., the person with normal hearing finds the sound louder by bone conduction. This "pseudo-negative Rinne" is due to stimulation of both the hearing organs by bone conduction as compared to one by air conduction. (2BC>1AC)

Bing Test.—The base of a tuning fork is placed on the mastoid and when hearing ceases, the meatus is occluded and if the fork is again heard, the Bing test is said to be positive.

Gelle Test.—Increased meatal pressure causes decreased cochlear response. Reversal of this phenomenon, increased loudness with more meatal pressure, was reported by Clarke[15] in 18.5 per cent of patients with otosclerosis.

According to Clarke,[15] absolute bone conduction is not determined by vibrations conveyed to the cochlea directly, but by sympathetic resonance of the cranial structure. The existence of conduction by resonance explains why the position of the fork stem on the skull is irrelevant. Cochlear reserve can be easily determined by comparison of the subject's absolute bone conduction (i.e., perception of a tuning fork placed on the mastoid, the meatus being closed by the finger), with a normal person's absolute bone conduction.

When the ears are both occluded and a vibrating tuning fork is placed on the glabella, lateralization would indicate a unilateral or unequal bilateral perceptive deafness. The tuning fork is then held close to the tragus, and transferred to the base of the mastoid when no longer heard by air. A conductive loss is present if the fork is still heard after the meatus is

occluded. Comparison with normal absolute bone conduction will now detect any additional perceptive loss.

Better lateralization of the Weber test is possible, according to Miodonski[16] when two turning forks are applied symmetrically to both parietal areas. One of the tuning forks vibrates but the other does not. Switching positions of the placebo fork and the vibrating one will give better orientation of the source of the "echo" tone.

Recruitment is an unequal loudness phenomenon due to cochlear circulatory disturbances (Fig. 2). It is



Fig. 3. Diplacusis is easily detected with a single tuning fork being heard at a different pitch in each ear.

typically found in Meniere's disease, and in other end-organ sensorineural lesions. When threshold tones are used, the better ear will hear the sound louder. However, when similar intensity tones are heard as of equal loudness, the affected ear is said to be recruiting. At higher intensities, the affected ear may actually hear the sounds louder than the better ear.

Moulden[17] found that when the 512 tuning fork is used on the vertex of the head, recruitment may exist if lateralization alternates, depending on the intensity of the tone. He suggested that recruitment may explain the confusing and unreliable results for the Weber test as reported in textbooks. Advantages of testing recruitment by the Weber test include minimum equipment and ease of performance.

Simple masking may be done by rubbing a sheet of smooth paper against the ear. A buzzing hum into a stethoscope will also effectively block out one or both ears for air conduction. The Barany noisemaker is of great help in ruling out a severe perceptive loss that seems to have good bone conduction but actually is a shadow response of the opposite good ear.

"Diplacusis" consists of a single tone being heard at a different pitch in each ear (Fig. 3). It is due to a tension imbalance of the conductive mechanism of one ear. The tuning fork can easily detect this phenomenon by testing first one and then the other ear with the same fork. When the fork is held against the vertex of the skull, two different tones may be heard. Following tympanoplasty or stapial surgery, diplacusis may be present for several weeks.

Summary

Tuning forks have been used for 250 years to standardize the pitch of various musical instruments.

A 512 tuning fork will quickly help in distinguishing a conductive hearing loss (BC>AC) from a perceptive type (AC>BC).

Proper masking is very important in determining true cochlear reserve.

Perceptive hearing losses may show recruitment or variable loudness imbalance.

Diplacusis should be suspected when distorted hearing is present.

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End Results in the Treatment of 203 Cases Of Carcinoma of the Larynx

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MANY AUTHORS have reported on relatively large series of results in the treatment of carcinoma of the larynx. A wide variety of therapeutic measures have been employed and various ones have been claimed to be the procedure of choice by individual authors.

It is the purpose of this paper to report one additional series of cases and to share our experiences with the accepted methods of dealing with this apparently increasing disease. No attempt will be made to establish an etiology or a preferred treatment for this often neglected condition.

This series is made up of 203 consecutive cases of carcinoma of the epiglottis, larynx, and pyriform sinus seen in the Out-Patient Department of the Henry Ford Hospital coming for diagnosis and, in most instances, definitive treatment for symptoms. These patients were seen between the years 1946 and 1960. It is recognized that the more recent cases have had relatively short periods of post therapy follow-up. Represented are the efforts of individual members of the Department of Otolaryngology over this fifteen-year period each with his own ideas as to management. The author personally directed the management of the majority of these patients.

TABLE I. AGE DISTRIBUTION

Age	Number of Patients
20-30	1
31-40	3
41-50	45
51-60	66
61-70	68
71-80	19
81-90	1
Total	203

Of the 203 cases, 193 patients were male and ten were female. This is typical of the series reported by others. Table I indicates the age distribution of our cases, the youngest of whom was twenty-eight years old and the oldest eighty-one. We note that the vast majority of cases fall in the sixth and seventh decades.

The smoking history of most cases was recorded and it was found that 163 smoked actively at the time of onset of symptoms or had smoked in the past. Only ten patients stated that they had never smoked. There was failure to record the smoking history in twenty-five patients. Hoarseness was their first symptom in 167 patients.

TABLE II. DURATION OF SYMPTOMS

Duration	Number of Patients
One month	18
Two months	37
Three months	27
Six months	41
One year	39
Two years or more	30
Not recorded	11
Total	203

Table II documents the duration of symptoms before definitive care was received by the patients. Many patients had consulted doctors only to be told that their hoarseness was due to laryngitis or excessive use of the voice and were given medication or assurance. Of interest here we note that 110 patients had had symptoms for six months or longer. Surely there is an object lesson here.

As indicated earlier, a wide variety of therapeutic measures were employed in the management of these cases, not uncommonly more than one procedure was necessary to control or attempt to control the disease.

Radiation therapy by 200 KV x-ray early in the series and by Cobalt 60 during the past eight years was used as a primary method of treatment in a total of sixty-nine cases. In some of these, surgery had been advised and refused by the patients or the lesions were felt to be inoperable. Of the latter, a few were later able to have surgery with the hope of obtaining a cure. Table III demonstrates the results of treatment in this group.

In eleven cases treated primarily with radiation, the

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patients later had laryngectomy. One of these has been free of disease for two years and six have been well for more than one year. Four of this group died with disease. Two additional patients had laryngectomy combined with radical neck dissection, one of whom has remained free of disease and one who died of his disease.

Table IV tabulates the results following laryngofissure or hemilaryngectomy. A total of thirty-eight

TABLE III. RADIATION—PRIMARY TREATMENT

Outcome	Number of Patients
Five years—cure	16
Four years—cure	2
Three years—cure	4
Two years—cure	18
One year—cure	13
Died with disease	12
Died without disease	
More than five years	2
Less than five years	4

patients fell into this group, of whom three later had radiation for recurrence and eight later had laryngectomy for incomplete removal or recurrence. Seven of the latter group were well for more than five years and one died at less than five years, free of his disease.

TABLE IV. LARYNGOFISSURE

Outcome	Number of Patients
Five years—cure	21
Four years—cure	4
Three years—cure	4
Died with disease	6
Died without disease	
More than five years	3
Less than five years	4
Last to follow up	
At one year	1
At two years	2

Table V tabulates fifty-three cases of laryngectomy, eight of whom later had radical neck dissection for metastatic disease.

Table VI indicates the results in fourteen cases of combined laryngectomy and radical neck dissection as a primary procedure. Obviously this group was made up of the more advanced lesions, many of them pyriform sinus involvement. As expected, the lowest survival rate is in this group. Of interest in this series is a group of six patients in whom a diagnosis of carcinoma *in situ* was diagnosed following removal of apparently benign polyps or nodules. None of

TABLE V. LARYNGECTOMY

Outcome	Number of Patients
Five years—cure	24
Four years—cure	5
Three years—cure	5
Two years—cure	1
One year—cure	7
Died with disease	11
Died without disease	
More than five years	2
Less than five years	2

these patients has required further therapy. Five have been well for at least five years; another is well two years after excision.

Eight cases of the series were either inoperable or the patients refused treatment of any kind when first

TABLE VI. LARYNGECTOMY WITH RADICAL NECK DISSECTION

Outcome	Number of Patients
Four years—cure	1
Two years—cure	1
One year—cure	5
Died with disease	6
Operative death	1

seen. One of these eight was lost to follow-up and one was reported elsewhere to be well and free of disease two years later.

The total survival rate for the entire series was 79.3 per cent. If the eight patients who were inoperable or refused treatment were to be eliminated, we have a survival rate of 83.3 per cent for all cases treated.

Summary

The results of treatment of 203 cases of carcinoma of the larynx and pyriform sinus are reviewed. A total survival rate varying from one year to five years of 79.3 per cent was obtained in this series. Particular emphasis should be placed on early diagnosis so that more successful therapy can be given.

Cancer can be far more effectively controlled by the general practitioner who brings his apparently well patients under careful and periodic scrutiny for precancerous lesions than by all the specialists, with their improved techniques of surgery and irradiation after a frankly malignant lesion has developed.

The Surgery of Deafness

IV. The Surgery of Otosclerosis

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UNDOUBTEDLY, the most frequently performed operations today for the relief of deafness are the stapes mobilization and stapedectomy for otosclerosis. Otosclerosis is an hereditary dystrophy of otic capsular bone, frequently of multicentric origin, with a predilection for that area immediately anterior to the stapes footplate. The dystrophic, highly vascular bone replaces normal bone at a very slow rate, and when it impinges upon the stapes footplate, immobilizes it producing a conductive deafness. The only symptom, deafness, comes on in young adulthood, and is slowly progressive. It is painless. Otosclerosis involves approximately 5 per cent of the white race, but produces clinical symptoms in only 12 per cent of those affected. Thus, there are probably eight million people in this country with otosclerosis, and of these, one million are afflicted with clinical otosclerosis.

The history of the surgery of otosclerosis is fascinating, because we think of the surgery of the ear as the pinnacle of modern microsurgery, whereas in reality little is being done today that was not conceived and actually performed nearly a century ago. The first stapes mobilization was performed by Kessel[1] in 1878, using some of the same techniques utilized today. He described a series of 20 mobilizations, many of which produced gratifying and lasting results. Other otologists of his day also performed many stapes operations with success; even stapedectomies were performed. What forced them to abandon their techniques is not known. It is known, however, that the leading otologists of the day roundly condemned this surgical interference and in a short time the direct attack upon the stapes was abandoned. The attempts to open the inner ear to the access of sound were shifted to other parts of the otic capsule, and it was not until the late 1930's that otosurgical principles established by several brilliant European otologists culminated in the development of the one-stage labyrinthine fenestration by Lempert.[2] There were several disadvantages to this monumental achievement, however, namely the often prolonged postoperative vertigo, the presence of a mastoid cavity, and the unfulfillment of the entire capability of the inner ear. Then, Rosen,[3] in 1953, re-discovered stapes mobilization and the relative ease with which normal hearing could frequently be regained. In 1957, Shea[4] re-discovered stapedectomy, and today this operation with its many variations is commonplace. Of the many who contributed to the evolution of the surgery of otosclerosis, probably the longest to be remembered will be Lempert, who by his perspicacity, profound respect for tissue, and sheer surgical ability, made surgical intervention in otosclerotic deafness "respectable."

Varieties of Stapes Operations and Results

All of the present-day middle ear operations for otosclerosis utilize the meatal flap approach developed by Lempert for another operation, namely the tympano-sympathectomy.[5] This latter procedure is no longer performed, but it gives the operator excellent access to the middle ear. The skin of the posterior canal is incised after local anesthesia is obtained, and the dermoperiosteum elevated down to the annular ligament of the tympanic membrane (Fig. 1). This ligament is elevated from the posterior half of its sulcus, leaving the canal skin attached to the tympanic membrane. The whole is then reflected forward exposing the posterior half of the tympanum. Some bone from the postero-superior canal rim must then be removed to expose the stapes, lower half of the incus, stapedial tendon, pyramidal eminence, and facial nerve. The whole operation save the first step or two is performed under the co-axially illuminated binocular operating microscope, at from ten to twenty-two magnifications. The operating field, in entirety about half the size of a little fingernail, is now ready, and any of the following may be performed.

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Simple Mobilization.—With a needle placed on the stapedial capitulum, gentle rocking motions are applied to the stapes in the direction of the tendon, diagonally, and supero-inferiorly. When only a minimal degree of tendency to heal by fibrous union whereas otosclerotic bone heals by bony union. In the operation, the anterior crus is partially cut away and the footplate fractured transversely behind the otosclerotic focus.

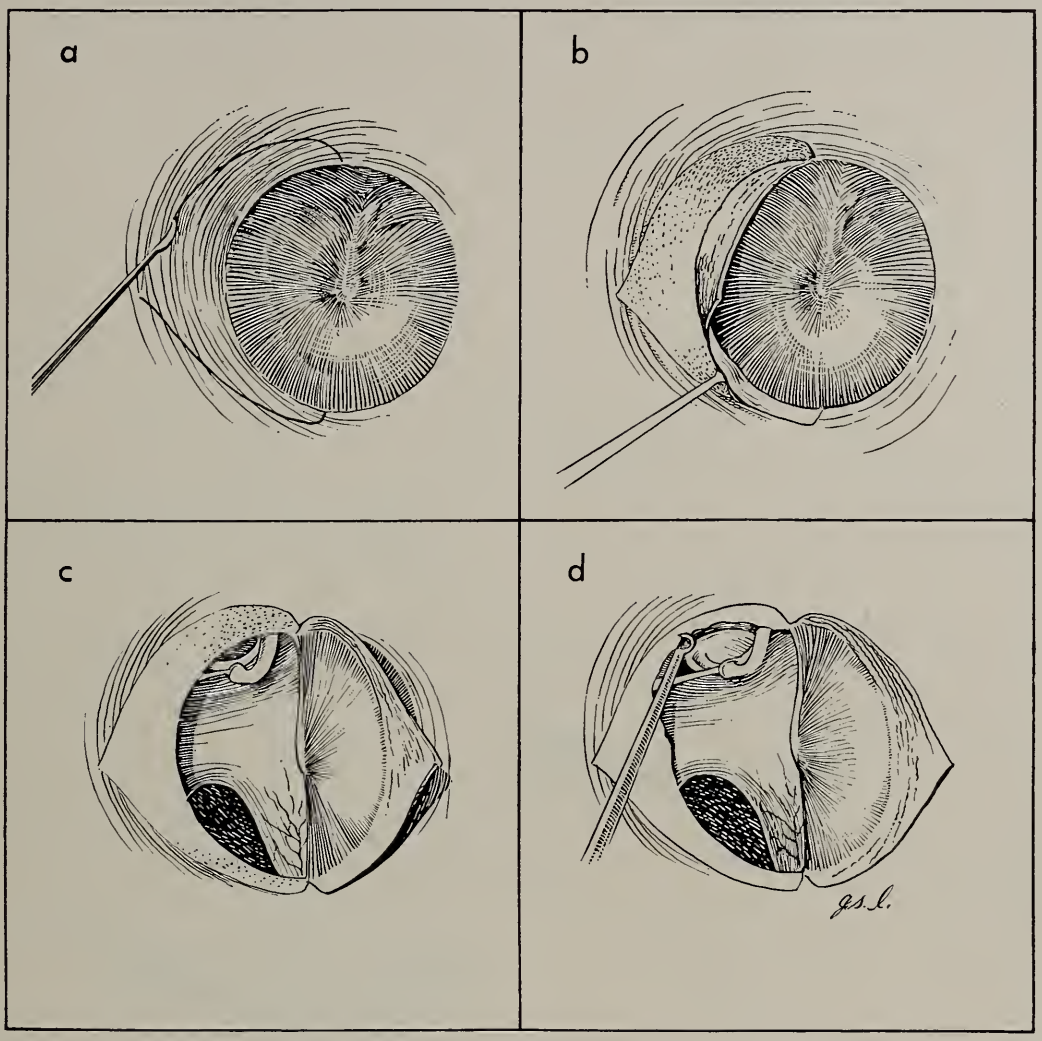


Fig. 1. Technique of Tympanotomy. A bullet-shaped incision is made with a sickle-knife (a) through skin and periosteum. Elevation of the dermoperiosteum is carried out (b) to the annulus tympanicus without detaching the skin flap from the tympanic membrane. The flap and tympanic membrane is reflected forward (c) exposing the posterior half of the tympanum and part of the incudostapedial joint. Removal of postero-superior canal bone exposes (d) the operative field.

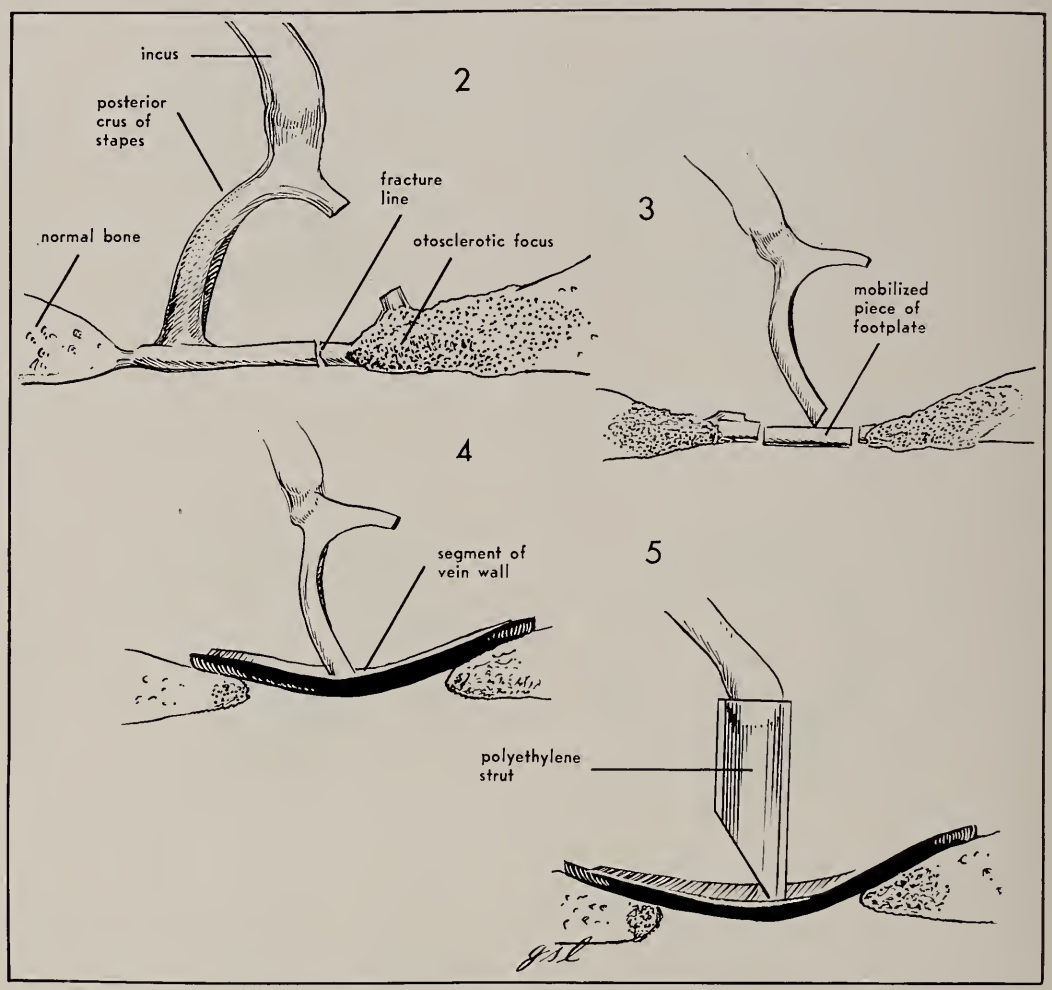
otosclerotic bone fixes the stapes, this may be attended by successful bobbing mobilization. If more than minimal fixation is present, refixation usually occurs in days to months. In our series, 26 per cent of simple mobilizations have held up longer than a year.

Anterior Crurotomy (Fig. 2.)—This operation was designed by Fowler[6] to take advantage of two features; first, at least one-fifth of otosclerotic ears have the focus restricted to the anterior third of the footplate, and second, normal stapedial bone has a strong This isolates the anterior focus while providing a mobile posterior assembly. It is productive of sustained serviceable hearing in 65 per cent of cases in our experience, with no instances of cochlear losses.

Crural Repositioning (Fig. 3).—An operation described by Juers is designed to take advantage of a central, uninvolved area of footplate by mobilizing it and swinging the end of the posterior crus over to meet it, producing a single-legged mobile stapes. A modification of this is described by Portmann, who resects

the anterior crus and stapes footplate, and interposes (Fig. 4) a sheet of fascia between the posterior crus and the oval window.

Stapedectomy and Prosthesis (Fig. 5).—Where circumferential, bipolar (anterior and posterior), or diffuse footplate otosclerosis is present, simple or perimeric footplate mobilization is a temporizing maneuver and bypass procedures are impractical. A total stapedectomy may then be indicated unless the thickness of a gnarled footplate makes this dangerous to the inner ear, which is the case in about 1 per cent of patients. The reconstructive principles embodied in this operation are merely the sealing of the open oval window with a free connective tissue graft which becomes a cicatricial diaphragm, and the placement of a rigid structure between this graft and the rest of the ossicular chain. A variety of tissues for the graft are available, including vein wall, perichondrium, fat, mucoperiosteum, and cartilage. For the crural replacement, stainless steel, polyethylene, free bone, and retained segments of crura are being used. Various combinations of the above grafts and prostheses have been described by different authors, and all are compatible with excellent



Figs. 2-5.

Fig. 2. Anterior crurotomy. An interior focus of footplate otosclerosis is present (right). The anterior crus is cut away and the footplate fractured just posterior to it. This mobilizes the posterior crus and two-thirds of the footplate.

Fig. 3. Crural Repositioning. The posterior crus is swung forward to contact a central mobilized island of footplate free of otosclerosis.

Fig. 4. Interposition. The footplate is resected, its place taken by a sheet of fascia or vein wall. The posterior crus is retained.

Fig. 5. Stapedectomy and Vein Graft. The entire stapes is resected, the footplate being replaced by vein wall and the crura by a polyethylene strut.

results when properly carried out. The degree of success in the reported series of various types of stapedectomy vary from 82 per cent to 92 per cent for sustained serviceable hearing or closure of the audiometric bone-air gap to less than 10 decibels. We use the Shea combination of vein graft and polyethylene prosthesis predominantly, with a success rate of 90 per cent. There have been no conductive regressions.

Discussion

This high rate of success with stapedectomy is most encouraging, but the over-all statistics are tainted with a small but significant group of patients which modifies one's enthusiasm. In from 0.5 per cent to 14 per cent of stapedectomies (depending upon whose series one considers), there occurs for some reason a moderate to severe inner ear deafness, with a decrease in bone conduction and an important impairment of the ear to discriminate speech sounds. In our series, this has occurred in 4 per cent. Whether this is due to sub-clinical suppurative cochleitis, intolerance of the inner ears of some patients to blood, an idiosyncratic fulminating atrophy of the organ of Corti precipitated by acoustic trauma, or some other factor or combination of factors is not known.

In our series and in numerous others, a significant inner ear loss has never followed an operation less than a stapedectomy. Primarily for this reason, one of the simpler operations is performed whenever that operation has a good chance of success. It has never been an acceptable surgical principle to perform a larger operation when a smaller operation will produce an equally good functional result. If, for example, an anterior crurotomy would have been all that was necessary to successfully restore hearing in 10 per cent of a series of 100 routine stapedectomies, then ten patients were needlessly exposed to the possibility of permanent inner ear damage. This seems self-evident, and yet the lure of the high success rate in stapedectomy has drawn some otologists to this operation as a routine measure. Until a method is devised to exclude from operation those with a propensity for inner ear damage, or the pathogenesis of the complication is delineated, this does not seem a justifiable course of action.

A number of criteria for stapes operations have been developed which serve as a guide at the University of Michigan Medical Center for the selection of operation. Conservation is the keynote, and will be until history delivers its decision.

Stapes Operation Criteria

I. *Simple Mobilization.* This is done in all cases where feasible. It may be feasible when the following conditions are fulfilled.
 - A. First operation. If a simple mobilization has been done before and has failed, a repeat simple mobilization will fail also.
 - B. A "blue footplate" (thin, translucent) is present.
 - C. Otosclerosis is anterior and minimal, or merely ligamentous.

II. *Anterior Crurotomy.* Requirements are twofold.
 - A. Blue Footplate.
 - B. Only anterior otosclerosis present, involving no more than the anterior third of the footplate.

 This operation is attempted wherever conditions permit. If the posterior crus is broken unintentionally, it usually fractures near the base. In this event, crural repositioning, interposition operation, or stapedectomy is performed, depending upon anatomical conditions such as footplate visibility, depth of the oval window, and others.

III. *Stapedectomy with Prosthesis. As long as it is assumed that any otosclerotic ear is amenable to a stapedectomy, severe inner ear losses will continue to occur as a complication at a maximal rate.*
 - A. Requirements
 1. Failure or non-feasibility of above techniques
 2. White or diffusely otosclerotic footplate
 - B. Conduct of stapedectomy
 1. The oval window and footplate after thorough denudation of mucoperiosteum must be scrupulously dry.
 2. The vestibule should be open the shortest possible length of time.
 3. Testing, plunger-like motions on the restored ossicular chain should be minimized.
 - C. The following categories shall be excluded from stapedectomy.
 1. The presence of obliterative footplate otosclerosis.
 2. Patients with a history of recurrent end-organ vertigo and fluctuation of hearing.
 3. Patients with a history of recurrent external otitis, a history compatible with an acute suppurative otitis media within three months, or the presence of thick, velvety middle ear mucosa at operation.
 4. Patients with a significant contralateral nerve deafness.

IV. Those excluded from stapedectomy may be offered continuance of their hearing aid, or a fenestration if a suitable candidate.

Efforts at Predetermining Extent of Otosclerosis

The only method known today of determining the extent of the otosclerotic process is by direct observation. Frequently, the exact distribution of the oto-

sclerotic bone escapes detection until removal of the crura and mucosa over the footplate. The degree of deafness present would seem to be a function of the degree of otosclerosis present, but this is not the case. One patient with a thick, solid white footplate might have only a 45 db loss, while another with minimal, anterior otosclerosis might have a 70 db loss. Since it is obviously better to be able to prepare a patient for only one course of action than the possibility of several during the operation (the different elections, variability of results, and the possible complications have already been listed), it would be desirable if the surgeon knew beforehand if the patient had minimal or advanced otosclerosis. The shape and position of the audiometric bone conduction curve varies greatly from one patient to another. To determine if this might give a clue to the answer, the bone curves of 100 patients with blue footplates and 100 patients with white footplates, all proven by direct examination, were compared (Fig. 6). It can be seen at a glance that not only the range but the heaviest concentration of bone curves are nearly identical in these two groups of patients. The only difference of any statistical significance detected was the presence of a Carhart notch (depression of conduction at 2000 cps with recovery at 4000 cps) in 50 per cent of those patients with white footplates, and only 25 per cent of those with blue footplates. There is a tendency to assume that the better the bone conduction is on the preoperative audiogram, the more lightly fixed is the stapes. Our comparisons do not bear this out.

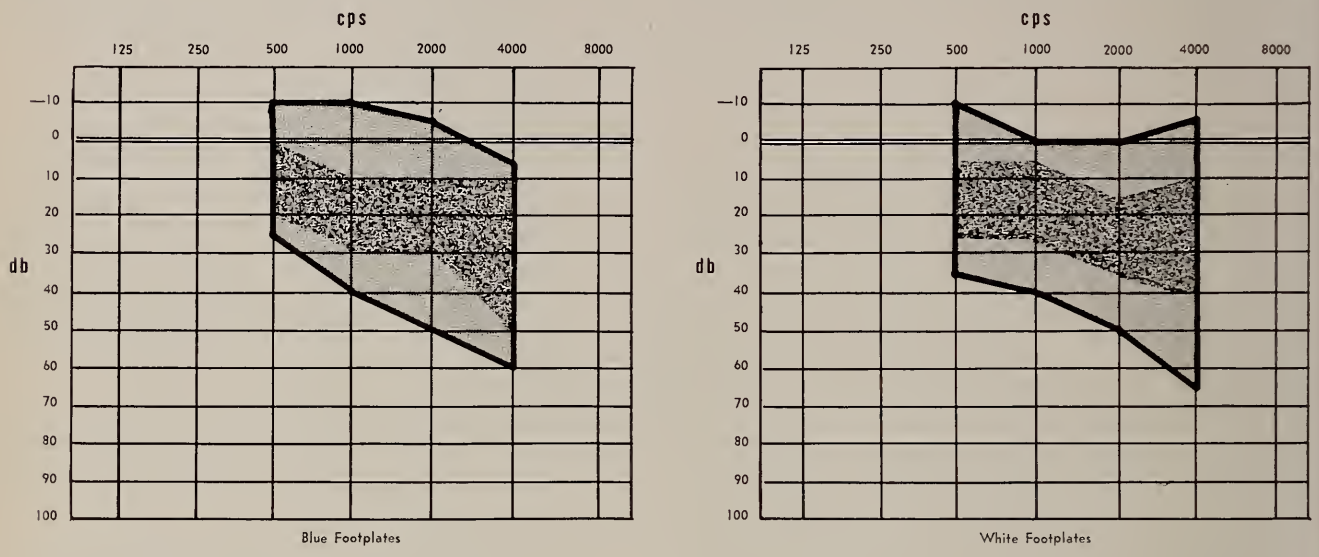


Fig. 6. Comparison of the preoperative bone conduction curves of two groups of patients. Those with blue footplates are represented to the left, and those with white footplates to the right. All bone curves fell within the lightly shaded areas, with the heaviest concentration of bone curves in the darkly shaded areas. The similarity of distribution regardless of whether the footplate was blue or white is striking. A Carhart notch occurred twice as frequently (50 per cent) in the white footplate series than in the blue footplate series (25 per cent).

Postoperative Rise in Bone Conduction

It is well accepted that following the fenestration operation, there usually occurs an increase in bone conduction greatest at 2000 cps, but also at the other three frequencies. This is assumed to be due to a release of the mildly immobilizing effect the closure of one window has upon the inner ear fluids. In order to determine if this were so for stapes operations as well, the preoperative bone conduction values of 200 patients were compared with postoperative values at the four usual frequencies. The results are tabulated in Table I. There was found to be a general rise in bone conduction involving most frequencies in the majority of operations. The rise averaged 5 db for each frequency after simple mobilization or crurotomy, but an average rise occurred at only the middle two frequencies after stapedectomy. At 4000 cps, there

TABLE I. POSTOPERATIVE BONE CONDUCTION CHANGES AFTER SUCCESSFUL STAPES OPERATION

(200 cases)

Type of Surgery	500 cps	1000 cps	2000 cps	4000 cps
Simple mobilization or crurotomy	+4 db	+7 db	+7 db	+3 db
Stapedectomy	0 db	+4 db	+5 db	−5 db

was an average drop of 5 db after stapedectomy. The failure of an equal rise after stapedectomy may be the result of acoustic trauma. If so, it stresses the importance of an operative technique as meticulously atraumatic as possible during this procedure.

Summary

Operations upon the stapes for the relief of otosclerotic deafness have been revived in recent years and brought to a high degree of effectiveness. There are numerous techniques available today, each with its indications depending upon surgical pathology. We believe that stapedectomy, the most commonly performed technique, should not be performed routinely because the incidence of complication is higher.

There seems to be no indication from an examination of the preoperative bone conduction curve which patient will be a candidate for a stapedectomy and which a candidate for a simpler operation.

A rise in bone conduction values following a successful stapes operation may be expected. This rise is greater following a simple operation than following stapedectomy.

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Detection of Glaucoma

A new plan to speed up the detection of glaucoma in its early stages and thus reduce the toll of blindness was announced recently by Dr. Luther L. Terry, Surgeon General of the Public Health Service.

In announcing the new plan, Dr. Terry pointed out that early detection and treatment is of utmost importance in glaucoma control. If detected too late, severe sight impairment and blindness are inevitable.

From a medical standpoint, Dr. Terry noted, the early detection of individual cases of glaucoma is now relatively easy. The problem is that not enough people take the tests regularly.

The new plan will collect and move information between the Public Health Service and official and voluntary health agencies throughout the Nation. It will:

1. Provide the Public Health Service with complete and continuous information on the extent and nature of glaucoma-detection activities across the country.

2. Provide official and voluntary health agencies with information on the best new methods of early detection of the disease.

Another important benefit, Dr. Terry said, will be better information on the actual prevalence of glaucoma in the United States.

The Public Health Service is now distributing questionnaires to all State and local health agencies conducting early-detection programs. The National Society for the Prevention of Blindness will make the questionnaires available to all its affiliates throughout the Nation.

Incoming information on the extent, methods and results of the various glaucoma-detection programs will be analyzed by the Public Health Service, and summaries will be issued periodically for the use of health agencies in their glaucoma-detection programs.

Professional Standards and Economic Status of Nurses in the United States

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ALL the current discussion on whether nursing is a profession seems to direct attention away from the central issue. The underpinning of nursing is the quality of service and the nature of the service. Lambertsen in her book, *Education for Nursing Leadership*, takes the view that the question is not whether nursing is a profession, but rather, is there a necessary element of professional function within the occupation.[1] She maintains that nursing is an occupation, a socially accepted occupation in the field of health services. Nursing is an essential service to the health and welfare of the citizens of the nation. The nature of the nurse's duties should speak for themselves. All the references to status or the social hierarchy nurses seek are not related to the duties performed. The focus of attention in Lambertsen's view must be on nursing rather than on the nurse.[1] Instead of claiming professional rank on the basis of status, the emphasis should be upon occupational competency.

Groups seeking status and recognition through the term "professional" rest their claim on: educational requirements, experience, and standards of behavior. While it is true that education is an important aspect of professionalism, nurses cannot claim professionalization solely on the basis of education. There are some nurses who have not kept pace with changes in nursing. For these, the learning process ended with graduation. They have not attended the growing list of courses, workshops, and clinics being offered for nurses which are designed to keep them properly informed. Experience likewise cannot serve solely as the basis for professionalism. What kind of experience really counts—taking temperatures? keeping records? being a supervisor? dispensing aspirins? Others can do these functions without any broad experience. Standards of behavior or professional ethics are also important, but standing alone they are insufficient for claiming professionalization. The standards of behavior are printed on quality paper; the words are well chosen; they sound well; there is a certain rhythm to the style used in putting the words together. Words alone, no matter how pious they may be, do not make for professional status.

Professional ethics are not something mysterious, nor do they take the form of some catechism. The standards, competency, and professional ethics take substance and form in the corridors, laboratories, hospital rooms, clinics, medical departments of business and industrial establishments, and wherever nurses discharge their job duties. The professional ethics are only so many words in a particular combination. They take on meaning through action, responsible action, both individual and collective action. It should be remembered that "by ye actions, ye shall be judged." Furthermore, status, like respect, cannot be given. It must be rightfully earned.

This is not to say that professional ethics are not important. They are. It is recognized that the professional nurse must not only be prepared adequately to practice, but must maintain professional status through continued reading, study, observation, and investigation. As indicated in the American Nurses Association, "A Code for Professional Nurses," the nurse has the "fundamental responsibility to conserve life and to promote health." This Code stresses both the patient-nurse relationship and the physician-nurse relationship. There are other aspects of this professional code, but two need sharp emphasizing:

1. "The nurse has an obligation to give conscientious service and in return is entitled to just remuneration."

2. "A nurse should participate and share responsibility with other citizens and health professions in promoting efforts to meet the health needs of the public."

Thus, it would seem that nurses have a two-fold responsibility. First, they are concerned with the health needs of the public. Nurses, in the words of a recent International Labor Office (I.L.O.) report, "supply the most exacting, comprehensive and responsible care of a nursing nature" available in a given country including those competent in research, consultation, education, and planning of health programs.[2] Second, nurses have a responsibility for the

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welfare of their group and for their own personal welfare.

Are professional nurses meeting these responsibilities? One dimension of the professional code is the responsibility for seeing that a sufficient supply of qualified nurses is available to meet current needs. The nation is reminded periodically of the shortage of nurses. Members of the various groups interested in nursing are spending considerable time, effort, and money in the recruitment of nurses. The success of these campaigns to date has been extremely limited. To put it more succinctly, they have failed to attract people to nursing in sufficient quantity to meet all the demands. Furthermore, they are doomed to failure unless all segments of the nursing profession seek sufficient improvement in the nurse's economic and occupational status. As the Committee on the Function of Nursing pointed out in 1948, "a major reason for the shortage of nurses is the traditional tendency to minimize economic incentives in rewarding nurses.

TABLE I. EARNINGS FOR THREE CLASSES OF NURSES IN THE UNITED STATES 1957-1959

Class	Average Weekly Earnings	Year
Industrial nurses* (Registered nurses)	$88.35	1958-59
Public health staff nurses**		1958
Local official health units	82.71†	
Non-official agencies	74.63†	
General duty nurses	64.27‡	1957

*Data adopted from *Wages and Related Benefits*, 20 Labor Markets, 1958-59. Bureau of Labor Statistics (Bulletin No. 1240-22), Washington, D.C.

**Data adopted from *Facts on Nursing*, p. 139, 1959 edition.

†Data computed from median annual salaries.

‡Data for female professional nurses in non-government hospitals in 16 major metropolitan areas. Data adopted from *Facts about Nursing*, p. 127, 1959 edition.

The profession has been losing potential recruits to competing professions and occupations."[3] This astute observation made thirteen years ago is still valid today.

What inducements are there for a person to become a nurse? What can young persons be told about the profession which will attract them? Recruitment materials place heavy emphasis on "service," on "glamor," and on "women in white" (crisp white uniforms). To be of service to mankind may attract those persons motivated by high ideals. It is apparent, however, that this approach has had limited success. As indicated in Table I, the monetary considerations for nursing are not overly attractive.

The range of average weekly earnings for three different classifications of professional nurses in the United States is from a low of $64.27 for general duty nurses to a high of $88.35 for industrial nurses. The public health staff nurses in local official health units received $82.71 a week while the public health nurses in non-official agencies received $74.63.

TABLE II. AVERAGE WEEKLY SALARY OR SALARY RANGE FOR THREE CLASSES OF NURSES IN MICHIGAN*

	Average Weekly Salary	Year
Industrial nurse	$98.68	1959
Public health official (range)**		
R.N.	$74.07-$ 84.35	1960
P.H.N.—IA	$83.11-$ 92.01	1960
P.H.N.—IB	$89.27-$ 98.58	1960
P.H.N.—II	$90.93-$103.70	1960
General duty (range)†	$72.81-$ 81.06	1960

*Data adopted from a study of the economic status of nurses in Michigan conducted by Avis Dykstra and D. H. Kruger.

**Data are for forty out of forty-three official city, county and district health departments. The respondents cited ranges rather than actual salaries paid.

†Data are for full-time professional nurses employed by 189 hospitals excluding state controlled and Veterans Administration. The respondents cited ranges rather than actual salaries paid.

Table II presents the data on three classes of nurses in Michigan. It is seen that industrial nurses, on the average, earned $98.68 per week in 1959. Full-time general duty nurses employed in 189 hospitals in the State received, on the average, between $72.81 and $81.06 per week. Registered nurses employed in official public health agencies received slightly more. They averaged between $74.07 and $84.35 per week. Table II also includes data on four classifications of public health nurses. The essential differences between these classifications are education and experience. A public health nurse IA earned, on the average, between $83.11 and $92.01, while a public health nurse II received, on the average, between $90.93 and $103.70 per week.

When the data for Michigan is compared with that for the United States, it is seen that nurses in the state fared somewhat better. The difference can be explained, in part, by the conditions prevailing in the labor market in Michigan. Employers of nurses compete with other employers for labor services. Because of the state's industrial complex, Michigan workers do receive higher wages, on the average, than do workers in less industrialized states. The wage and salary programs in industry and business have an impact on the compensation of nurses.

The significance of these weekly earnings of these nurses is brought into sharp focus when compared with the occupational earnings of other groups of workers such as secretaries, teachers, and truck driv-

ers. These comparisons are made in the absence of any definite yardstick which can be used to measure the economic position of nurses. There are difficulties inherent in this kind of comparison. Job content, educational requirements, preparation, skill, and responsibility vary.

It is, however, difficult to understand the rationale for the low salaries of professional nurses. In a free labor market, employes, for the most part, are paid according to their contribution which is largely determined by the job to which they are assigned. In basing compensation on contribution, employes have accepted the principle that jobs be valued in terms of their significance to the organization.[4] The value of the job in relation to other jobs within the organization thus becomes the criteria for pricing of a given job, i.e., the wage or salary paid. In determining the relative value of jobs and in setting a price on them, many employers, especially the larger ones, have adopted job evaluation systems. While the systems may differ, the essential components are similar.†

Determining the compensable factors is the core of job evaluation. These factors, when analyzed for each job, place one job at a higher level in the job hierarchy than others. Higher rates of pay are assigned those jobs which are at a higher level. The most common compensable factors used in the job evaluation systems are: mental requirements, skill, effort, responsibility, and working conditions. Using these factors, it would seem that nurses should receive a much higher level of earnings. It is apparent, however, either that distortions have developed in the systems used or that some other method of wage and salary determination has been devised for the nurses. Another possibility is that employers may not have recognized the contribution and significance of nurses to their organization.

Another inducement which is used to attract new entrants into nursing or to keep experienced nurses in nursing is the high status of the group. Nurses do have high occupational status.[5] Nurses have had a long tradition for such status. One possible explanation may be found in the nature of service performed and in their close identification with the medical profession.* The physician enjoys the highest status of all occupational groups.[5] This suggests a "spill-over effect" or status through osmosis. While the occupational status may be high, it is clear that professional nurses do not enjoy the same high economic status.

It is difficult to make a strong status appeal in face of these earning differentials. Income is a fundamental factor in status. As Miller and Form point out, "contemporary Western culture is materialistic and it tends to measure social honor in economic terms."[6] Many persons apply a pecuniary yardstick in measuring status. A better job is, in many instances, a better-paying job. While there is much criticism about the growing emphasis on materialism, status tends to parallel economic levels.

The data on nursing manpower appear to substantiate that current inducements are insufficient to attract the number of nurses needed to meet all demands for nurses. In January, 1958, it was estimated that there were approximately 460,000 employed professional nurses in the United States.[6] This represented a gain of 30,000 over the 1956 estimate. Most of this gain has been attributed to the increases in part-time employes and the return of married inactive nurses.[6] While this gain represents approximately a 7 per cent increase, there are still unmet nursing needs. One measure of need can be expressed in terms of the ratio of nurses to population. In 1958 there were 268 employed professional nurses per 100,000 population in the United States. A reasonable goal is 300 nurses per 100,000 population according to the National League for Nursing.[6] Therefore, to meet this standard will require 56,000 additional nurses. Although the number of professional nurses is increasing, the population of the nation is also increasing. The rapid population growth of the nation has accentuated the shortage of professional nurses.

Michigan is also experiencing a shortage of professional nurses. Currently (1960), there are approximately 29,000 registered nurses in the State. Of this number it is estimated that only 15,515 registered nurses are employed. With a population of 7,750,000 in 1960, Michigan has 214 active registered nurses per 100,000. As indicated above, the National League for Nursing has recommended a minimum ratio of 300 per 100,000. On this basis, Michigan should have 22,675 *active* registered nurses. Thus, the current shortage of registered nurses in Michigan is estimated to be 6,160. Viewed another way, the state has 72 per cent of the total of registered nurses needed to supply adequate nursing care.

†For a more detailed explanation of job evaluation systems, see Belcher,[4] Chapters 6-10.

*For a more general discussion of status, see Industrial Sociology by Delbert Miller and William Form. New York: Harper and Brothers, 1951, Chapter XI. Other good references may be found in the references of this chapter.

As the I.L.O. report (cited earlier) pointed out, nurses supply "the most exacting, comprehensive and responsible care of a nursing nature . . ." Nurses are responsible to the patients. According to Tyler, "The nurse is primarily dedicated to the welfare of those she serves, to the maintenance and improvement of their physical and mental health."[7] The question may well be asked: Can the nurse be dedicated to the welfare of those she serves when there are so many patients to serve? With the shortage of qualified nurses, what kind of patient care is being rendered? The growing complexity of health care in 1960 requires an adequate supply of qualified personnel to provide this kind of care. Recent publicity has dramatized the shortage of nurses.**

In addition to the nurses' responsibility to the patients, the nurses are also responsible to their employers. This means primarily that the nurse discharge her duties in a creditable manner, that she work effectively and efficiently in furthering the objectives or goals of the organization. It does not mean that the nurse should assume the entire responsibility for solving the economic problems of her employer in order to provide adequate nursing care. The nurse should be paid commensurate with her education, skill, and job responsibilities. It is not her role to subsidize the cost of health care. It is the public's responsibility to decide the quality of nursing care it desires and to meet the cost of this care.

There are references in literature to the three-fold responsibilities of nurses; their responsibility to the patients, to the doctor if they discharge their job duties under the doctor's supervision and to their employers.[8] Nurses, however, have a fourth responsibility. They have a responsibility for the welfare of their group and for their own personal welfare. According to the American Nurses' Association, "It is the nurse's responsibility to work for the improvement of conditions of employment in order to make it possible for her to render nursing service at the maximum of her efficiency."[9] There is considerable evidence which suggests that nurses have not fully met either their responsibility for their group or for their personal welfare. While some improvements have been made,‡ there remains much to be done if the professional standards and economic status of nurses are to be improved.

Bixler and Bixler point out that a profession, "strives to compensate its practitioners by providing freedom of action, opportunity for continuous professional growth and economic security."‡ The economic security of nurses has not kept pace with the rapid changes of the last ten years. The pressures exerted by the rising cost of living also affect nurses. While nurses may not be grounded in economic theory and the price mechanism, they do know what their pay check will buy in terms of food, shelter, and clothing. The nurses' economic welfare depends not on how much money income she receives, but on the purchasing power of her income, the amount of goods and services which she can buy with it. Since purchasing power and the nurses' economic welfare are so intertwined, one of the keys to work satisfaction is the relationship between her pay and the money she spends to feed, clothe, house her family, and for paying baby sitters.

The quantity and quality of goods and services which the nurse can purchase are related to the "cost of living" in her community. There are, however, no completely satisfactory measures of retail prices. The nearest satisfactory measure is the Consumer Price Index, commonly referred to as the cost-of-living index, published by the U. S. Bureau of Labor Statistics. This index measures the average change since the period 1947-1949 in the retail prices of goods and services purchased by urban wage earner and clerical worker families. The index is compiled on the basis of data on prices collected in forty-six cities across the country.

In the period 1949-1959, the Consumers Price Index increased by approximately 25 per cent.§ If the individual items which make up the Index are examined, more impressive increases have occurred. Public transportation increased 93.0 per cent; rent up 39.7; medical care increased 50.8 per cent; all services up by 45.8 per cent, and footwear up by 35.2 per cent. Personal care increased 31.2 per cent.

While living costs mounted, various occupational groups in the economy have sought to keep up with these increases. For example, the average weekly

**The front page of the *New York Times* of September 25, 1959 carried these headlines: "2 Baby Deaths in City Hospitals are laid to Shortage of Nurses." In the article, it was charged that these deaths occurred because of the shortage of nurses. It was also pointed out by the Commissioner of Hospitals that the Department of Hospitals had positions for 8,200 nurses, but had only 3,400 on its payrolls.

‡For some indications of the extent of these improvements, as seen by two close observers of nursing, see Genevieve K. Bixler and Roy W. Bixler, "The Professional Status of Nursing," Amer. J. Nursing, pp. 1142-1147 (Aug.) 1959.

§For more complete information on the Consumer Price Index, see United States Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review*. p. 223 (Feb.) 1960.

earnings of production workers in manufacturing industries increased from $54.74 in 1948 to $89.24 in 1959, an increase of about 65 per cent. Steelworkers received average hourly earnings of $1.44 in 1947 and $3.10 in 1959, an increase of about 115 per cent. By comparison, the average weekly salary of general duty nurses in 1948 was $48.00, and $64.00 in 1957, a gain of 33 per cent. For a forty-hour week, this would be $1.20 an hour in 1948 and $1.60 an hour in 1957.

While these comparisons may not be entirely accurate, they at least indicate that the earnings of nurses, on the average, are not keeping up with those of production workers. Although Bixler and Bixler point out that professions can only imperfectly repay their practitioners by their service to society,‡ it does seem that nurses have indeed lagged behind. The data on earnings indicate that nurses as a group are not meeting the responsibility for the welfare of their profession. The nurse professes "to do all in my power to maintain and elevate the standard of my profession."

Professional standards of nursing and the economic status of nurses are, in part, interrelated. Reference has already been made of the failure of the profession to attract a sufficient quantity of new recruits. The patient loads and the quality of patient care have been affected by the shortage of qualified nurses. Because of employment practices of employers, coupled with the shortage of nurses, the professional nurse is witnessing a growing number of non-professional personnel performing services which should only be performed by competent registered nurses. How employers treat the professional nurses on the job, including compensation which injures personal dignity and integrity, affects professional standards. Their working conditions and job assignments are likewise matters affecting professional standards. The passive attitude of nurses towards their economic status is a matter pertinent to their professional standards.

To enhance their professional standards, nurses must also improve their economic status. Achieving new economic status may well require the development of different institutional arrangements. Nurses working through their professional associations must seek out solutions or a series of solutions to the economic problems which beset the professional nurse. In a free society, the decision to improve their economic status will be made by the nurses themselves.

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Interesting Statistics

More than 2.5 million persons now are engaged in work related to maintaining the health of the American people. The 1940 census showed that there were 1.0 million persons in these fields, and in 1950 the number had grown to 1.6 million.

* * *

A total of 73,565 new students were admitted to schools of professional and practical nursing in the United States during 1960, compared to 71,297 in 1959. The 1,152 professional nursing programs offered in hospitals, colleges and universities, and junior colleges, admitted 49,787 new students in 1960, an increase of almost 2,000 over the 47,797 who entered in 1959. Estimated admissions to practical nursing programs for the same period showed a slight increase from 23,500 to 23,778. There were 661 such programs last year, compared to 607 in 1959.

Prolonged Convalescence Following Uncomplicated Surgery---Why?

R. Lomax Wells, M.D.
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IT has been pointed out by Ravdin[1] that the wide variety of interests relating to surgical convalescence have produced papers covering "the entire period of convalescence from the minutiae of tissue behavior through the psychological elements involved." His remarks had specific reference to the papers in the comprehensive and classical monograph[2] on Surgical Convalescence published September 10, 1958, by The New York Academy of Science.

The shift to early ambulation following surgery has produced a re-focusing of attention on the convalescent and the rehabilitation period. In many instances, surgical convalescence (especially that following uncomplicated surgery) appears to be prolonged beyond what would appear to be a safe and reasonable period of time in view of all the presently known factors. This is costly and, in many instances, does not seem to be in the best long-range interest of the patient.

Industry must look upon its medical and benefit services, hospital, surgical, and other sickness insurance costs from two points of view. One point of view might be called selfish—if running the business in the best interests of the employee, the customer and the stockholder, can be so considered! It seems to me that this is not really selfishness but simply a matter of survival in the competitive markets of today—and of making sure that the business makes a profit. Survival of any business in our system of free enterprise without reasonable and adequate profits is short-lived. The profit system as practiced under our concept of free enterprise and democracy is being challenged by many of our friends among our allies and is, of course, being constantly and viciously assailed by the communists.

The second point of view of an industry towards these many and increasing employee benefits is certainly humanitarian and represents one of the many ways in which the corporate body is recognizing and accepting its social obligations. People are the most necessary and vital asset of any business. Sick people must be cared for in many ways and by many people. When a company provides fringe benefits, abuses arise —some conscious, some subconscious; some deliberate, some not. Every employee should be treated with dignity and receive any and all benefits to which he is rightfully entitled, but abuse by a few results in problems for the many. Prolonged absence following uncomplicated surgery in many instances may well represent such an abuse.

Let us take a look at the magnitude of the problem of return to work after surgery. There are approximately 64 million workers in the labor force (excluding the Armed Forces). According to the Summary Report of the Research Council For Economic Security on Prolonged Illness—Absenteeism (1953-56),[6] the rate for workers of prolonged absence following surgery was 32 per 1,000 man-years of exposure. This same report defines the average duration of such absences as 10 weeks for both sexes. On this basis, there was an estimated 2,048,000 weeks per year of lost time due to prolonged absence following surgery. Assuming the same number of weeks lost in 1959 and an average gross weekly earning of $90, the yearly cost of prolonged absence following surgery equates to $184,320,000.

Before discussing some experiences with absences following surgery, a brief review of some of the basic

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physiologic and body chemistry factors involved seems in order at this point.

Return to preoperative baselines by the fifth postoperative day in uncomplicated surgical cases has been reported for creatine levels, corticosteroids, eosinophiles, et cetera.

And, according to a study done by Howes and his associates[3] in 1929, the following are of significance in our knowledge of wound healing: (1) Skin wound

REVIEW TABLE I. UNCOMPLICATED APPENDECTOMY

(1) *Total number of cases*—335
Chart 1

(2) *Ranges in Days*
Chart 2

(a) *Minimum*
Men: 11 days (Md.)—20 days (Md. Sub.)
Women: 12 days (W)—19 days (W. Va.)

(b) *Maximum*
Men: 38 days (W)—55 days (Va. Adm.)
Women: 44 days (W. Va.)—68 days (Md. Adm.)

(3) *Total Days* *Range in Days*
Chart 3
Men: 3117 23 (W)—32 (W. Va.)
Women: 6892 29 (W)—36 Md. Sub.)

Total: 10,009
Average in days—29.8 (male and female)

—maximum strength reached in eleven days. (2) Fascia—maximum strength reached in thirteen days. (3) Muscle wounds—maximum strength attained in twelve days. (4) Total abdominal wall—maximum strength in twelve days.

REVIEW TABLE II. UNCOMPLICATED HERNIORRHAPHY

(1) *Total number of cases*—85
Chart 4

(2) *Ranges in Days*
Chart 5

(a) *Minimum*
Men: 18 days (Va. Adm.)—25 days (Md. Sub.)
Women: 19 days (Va. Adm.)—67 days (W. Va.)

(b) *Maximum*
Men: 49 days (Md. Sub.)—72 (Md. Adm.)
Women: 42 days (Va. Sub.)—78 (Va. Adm.)

(3) *Total Days* *Range in Days*
Chart 6
Men: 2884 37 (Va. Adm.)—42 (Md. & Va. Sub.)
Women: 639 (W. Va.)—58 (Va. Adm.)
Average in days—41.44 (male and female)

Moore[4] has divided convalescence into four phases:

1. *Injury or Adrenergic Corticoid Phase.*—This lasts two to three days. It starts with trauma. There is a loss of lean tissue and fat and a relative gain in body water. Corticosteroid changes are most marked in the first few hours of the illness during which water and salt are withdrawn from the renal tubules. Lean tissue loss reveals itself in nitrogen loss which is in direct proportion to the severity of the injury.

The patient is weak, listless, has no appetite and prefers to be quiet and alone. During this phase the wound is entirely reliant on its sutures; there is no tensile strength.

2. *The Turning Point or Corticoid Withdrawal Phase.*—This phase may last only one or two days. It has been recognized by surgeons for centuries and characterized by house staffs as "positive lipstick sign," i.e., the corner toward recovery is turned.

Lean tissue catabolism decreases and there is a reduction in the absolute urinary excretion rate. Peristalsis returns, flatus is passed per rectum, water and salt excretion increases and the patient desires food.

REVIEW TABLE III.
UNCOMPLICATED HEMORRHOIDECTOMY

(1) *Total number of cases*—191
Chart 7
Men: 95
Women: 96

(2) *Ranges in Days*
Chart 8

(a) *Minimum*
Men: 9 (Md. Sub.)—21 (Va. Sub).
Women: 10 (Va. Adm. & Sub.)—32 (Md. Sub.)

(b) *Maximum*
Men: 41 (Va. Adm.)—73 (W. & Va. Sub.)
Women: 49 (Md. Adm.)—81 (Va. Sub.)

(3) *Total Days* *Range in Days*
Chart 9
Men: 2424 21 (Md. Sub.)—33 (Va. Sub.)
Women: 3337 26 (Md. Adm.)—39 (Md. Sub.)

Total: 5761
Average in days—30.1 (male and female)

The wound gains tensile strength rapidly and sutures may be removed. The wound is free of acute pain.

3. *Strength: Spontaneous Nitrogen Anabolism Phase.*—This long period of muscular regrowth and spontaneous anabolism will not occur without diet. Moore states: "During this period the patient gains strength and, after civilian surgery, can be sent home . . . exogenous caloric intake must be in excess of

work output if protein synthesis in muscle is to occur. Therefore, the patient should not return to work too soon."

The end of this phase of convalescence is influenced by "the genetic constitution, the sex, the age, and the external work requirement of the individual." The patient becomes "hungry, ambitious, gabby, and bored" (Pace)[3] during this period which begins on the seventh to tenth postoperative day and lasts nine to thirty days.

4. *The Fat-Gain Phase: Fat Redeposition.*—The patient gains weight for several months. Total body water remains constant, i.e., the mark of fat gain. "When the patient's body weight has returned to normal, the fat-gain phase is over and biological convalescence has ceased."

With this brief review of some of the basic chemical and physiologic factors involved in surgical convalescence, it seems appropriate now to review some

REVIEW TABLE IV.
UNCOMPLICATED DILATION AND CURETTAGE

(1) *Total number of cases*—552

Chart 10

(2) *Ranges in Days*

Chart 11

(a) *Minimum*
6 (Wash.)—11 (W. Va.)

(b) *Maximum*
34 (Md. Sub.)—97 (Wash.)

(3) *Total Days* *Range in Days*
11,150 17 (W. Va.)—22 (Va. Adm.)

Chart 12

Average in days—20.1

practices and experiences currently available to us. Perhaps we can then draw some broad but pertinent conclusions—conclusions pertinent to individual welfare and pertinent to the economics of this problem as it affects an employee and his employer.

In The Chesapeake and Potomac Telephone Companies, we have reviewed our experience with *uncomplicated* operations such as appendectomy, hysterectomy, dilation and curettage, herniorrhaphys, and hemorrhoidectomys—during the years 1956-1958. Charts reflecting the number of cases, "range in days" and "total and average days" for each procedure are reviewed and the highlights of these charts are outlined in Review Tables I through V for purposes of summarization and simplicity.

In the charts (1-17) and tables I-V), the captions are abbreviated as follows:

W —Washington, D. C.
Md. Adm. —Maryland
Md. Sub. —Maryland areas suburban to Washington, D. C.
Va. Adm. —Virginia
Va. Sub. —Virginia areas suburban to Washington, D. C.
W. Va. —West Virginia

These areas define certain corporate and administrative areas within the four Chesapeake and Potomac Telephone Companies.

REVIEW TABLE V. UNCOMPLICATED HYSTERECTOMY

(1) *Total number of cases*—146

Chart 13

(2) *Ranges in Days*

Chart 14

(a) *Minimum*
17 (Va. Adm.)—46 (W. Va.)

(b) *Maximum*
52 (W. Va.)—189 (W)

(3) *Total Days* *Range in Days*
9,120 50 (W. Va.)—71 (Va. Sub.)

Chart 15

Average in days—62.4

TABLE A. TOTAL DAYS AND COST FOR ALL SURGICAL PROCEDURES

Company	Total Dollars	Total Days
Washington	$ 96,218.34	9,415
Maryland administrative	67,337.26	8,840
Virginia administrative	97,904.88	14,515
West Virginia	21,338.33	2,477
Maryland suburban	16,113.60	1,634
Virginia suburban	15,013.85	1,573
Grand total	$313,928.26	38,454

TABLE B. DISABILITY ABSENCE—MEDICAL*

Disability Cause	Number Cases	Total Time	Average Time
Acute sinusitis	79	1,204	15.2
Common cold	125	1,327	10.6
Duodenal ulcer	132	6,019	45.5
Heart disease	112	11,845	105.7
Influenza	889	12,115	13.6
Pharyngitis	75	1,101	14.6

*Michigan Bell Telephone Company.

Table A shows total days (38,454) and total costs ($313,928.26) for the five surgical procedures studied in the three-year period 1956-58, inclusive. This equates to $8.11 per day for days lost through these

procedures. Thirteen hundred and nine (1,309) employees were involved (between 4 per cent and 5 per cent of total employee group). This averages almost

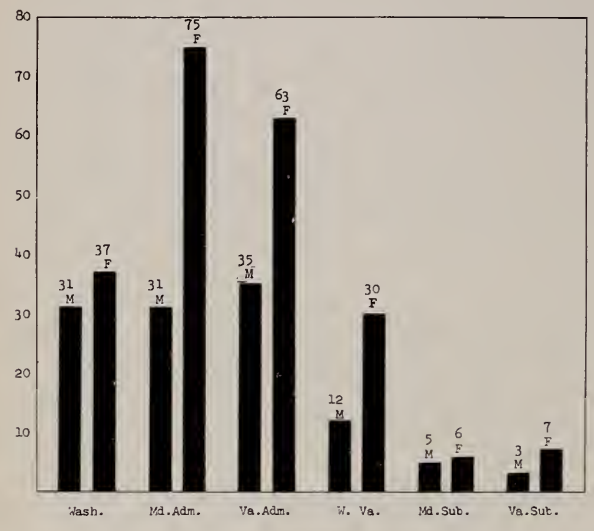


Chart 1. Number of cases—appendectomy.

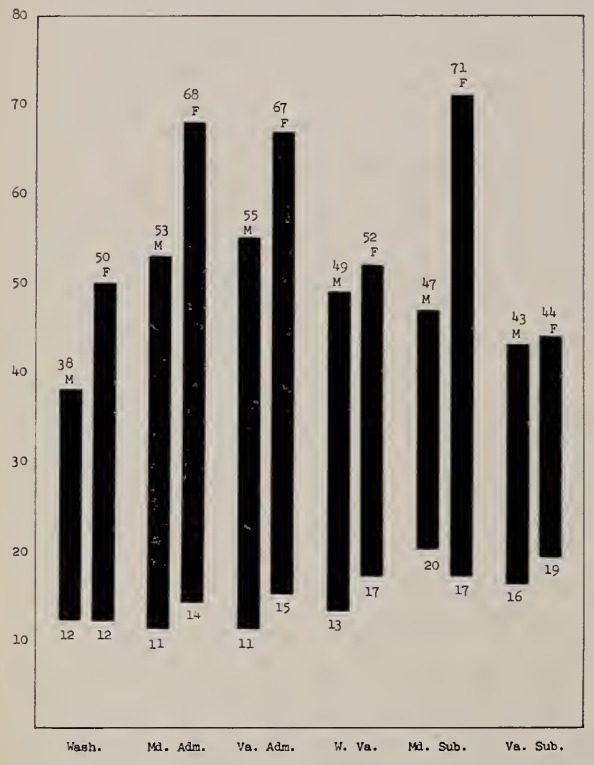


Chart 2. Range in days—appendectomy.

$240 per employee for an average absence of twenty-eight days.

Letters were sent to 100 gynecologists in the Washington, D. C. Metropolitan Area and to eighty-five gynecologists in the Baltimore, Maryland, Metropolitan Area, asking their opinion regarding return to work following *uncomplicated* dilation and curettage, and hysterectomy. There were seventy-three respondents in Baltimore and eighty in Washington. Their replies revealed a marked variation in the opinions of gynecologists as to the appropriate interval between uncomplicated dilation and curettage and safe return to work. This varied from 3 to 21 days with the largest number of physicians (35 out of 153) specifying 7 days. Obviously, this is at variance with our experience and that of others as shown in Chart 17.

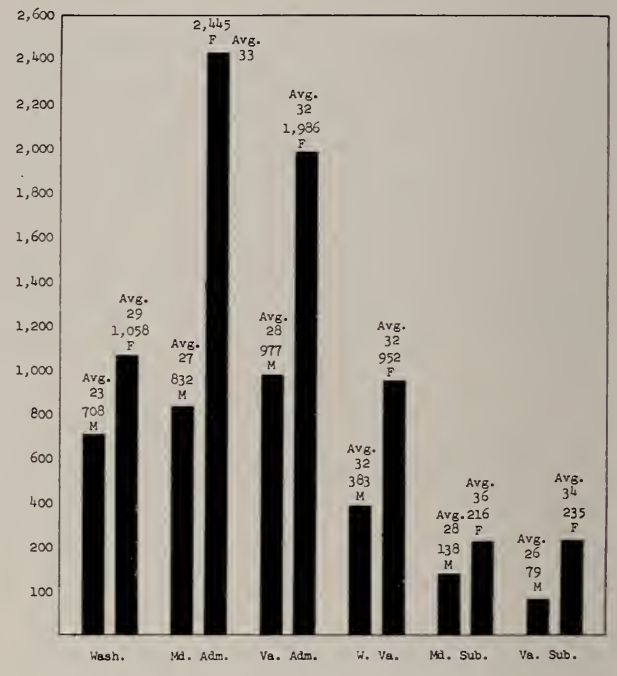


Chart 3. Total and average days—appendectomy.

There was also a considerable variation in the opinions of these gynecologists relative to absence from work following uncomplicated hysterectomy. There was a spread from 21 to 70 days with 40 of 153 respondents indicating 42 days. It is of interest to note that 22 respondents reported 28 to 42 days and 29 reported 28 days. Certainly the majority indicated 28 to 42 days as a safe convalescent period. This is at variance, too, with Chart 17 illustrating our experience and that of others.

Charts 16 and 17 compare the over-all averages for post-surgical absences in our C. and P. Companies with two other Bell System Companies, a non-Bell System Company (Dupont), an insurance company, the Air Force, and the Dohan Study.[2] The Dohan Study represents the opinion of 120 professors of surgery and board certified general surgeons on reasonable times for returning patients to defined light and heavy work in certain specific uncomplicated surgical procedures. The wide range of figures evident

in these two charts indicates a need for the continuing education of the patient and the personal physician as well as management and its medical advisors in this area. Evidence continues to accumulate that such education if successfully applied will prove mutually beneficial to all parties concerned.

"Stay in bed" has long been one of the cardinal rules of treatment. This advice has been based on the observation that in general sick people do not feel

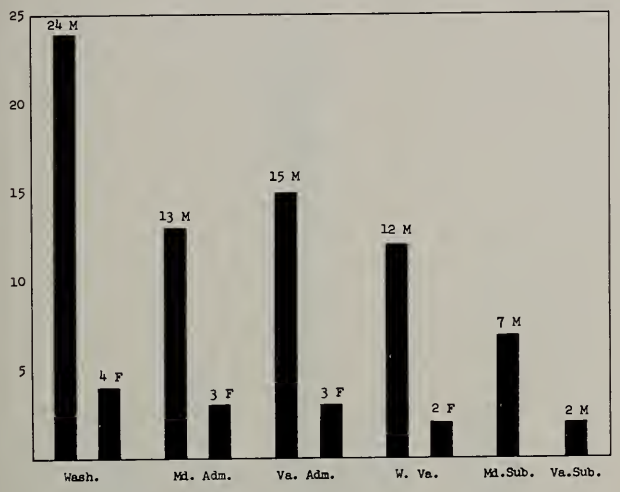


Chart 4. Number of cases—herniorrhaphy.

like getting up and around. It seems fair to state that few, if any, would deny the value of and necessity for bed rest during acute medical conditions. Recently, however, certain investigators have questioned and reexamined the necessity for or the advisability of prolonged bed rest in rheumatic fever, nephritis, and peptic ulcer—diseases in which prolonged bed rest and convalescence have always been considered necessary. Of 360 children studied by Lendrum, Simon and Mack.[7] 269 were allowed early physical activity as temperature, leukocyte count, sedimentation rate and pulse rate approached the normal. The authors found no deleterious effect on the heart resulting from earlier physical activity. The proportion of patients better, worse, or the same after five years was essentially the same in those with early activity and those with prolonged bed rest.

McCrory[8] and associates allowed thirty-five children with acute nephritis to resume physical activity as the acute symptoms, i.e., edema, hypertension, and hematuria disappeared. In thirty-four of the thirty-five, the glomerulonephritis was completely healed two years after the acute episode.

Rapid "mobilization" of patients after bleeding from peptic ulcer resulted in progress as good as those kept in bed a week longer, according to Pollard and Summerskill.[9]

These three reports should not be used to deny any patient close supervision during convalescence.

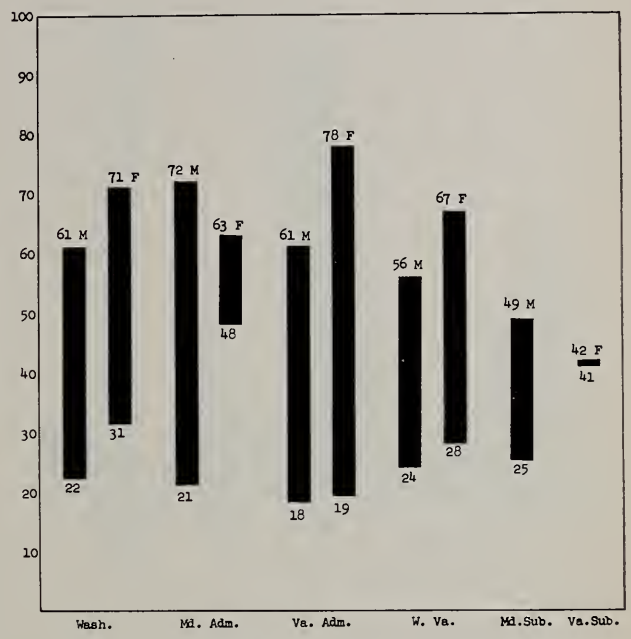


Chart 5. Range in days—herniorrhaphy.

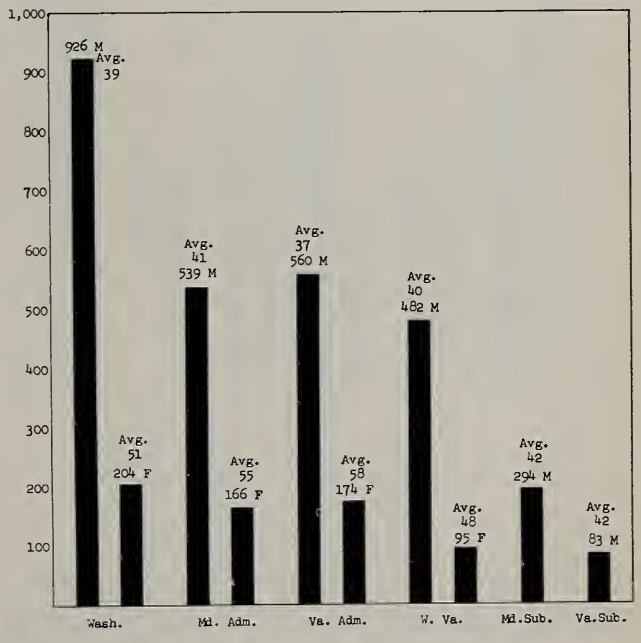


Chart 6. Total and average days—herniorrhaphy.

Each patient must be evaluated individually. The social and economic advantages of early return to home and job would seem to be significant. Perhaps all these reports do is to raise doubt as to the necessity for routine prolonged restriction of activity after certain illnesses.

I am indebted to Dr. William Jend of the Michigan Bell Telephone Company for the information presented in Table B. This is shown to provide you with one company's experience with six commonly encountered

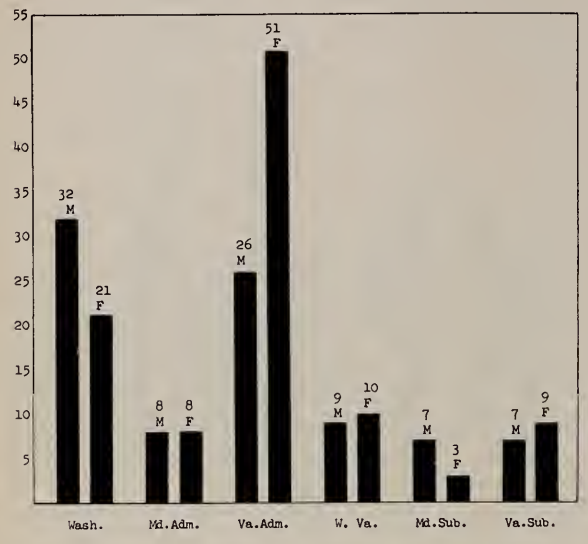


Chart 7. Number of cases—hemorrhoidectomy.

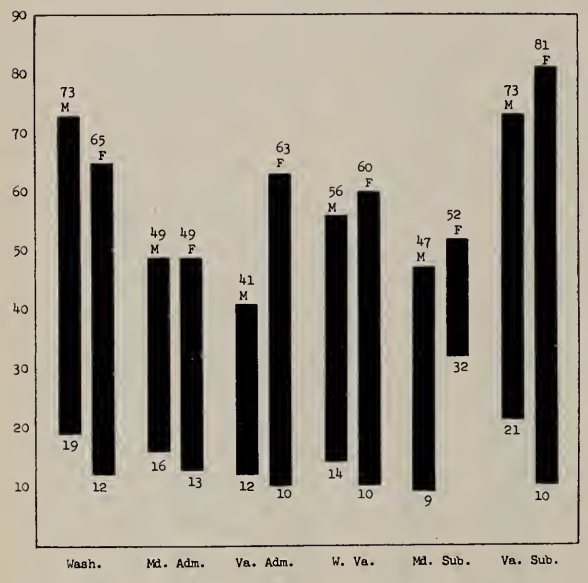


Chart 8. Range in days—hemorrhoidectomy.

medical conditions. It emphasizes the need for similar studies in other companies so that experiences resulting from non-surgical absences can be compared and correlated. I would hope that such studies would provide us with a picture of wherein lay some of our problems and the trends involved. Such figures, however, should *never* be used as averages to match against any individual employee experience—false conclusions harmful to the patient and the company could very well be the end result of such comparisons.

In this connection, Dr. Jend has made the following pertinent comments: "However, since a reduction of just a few days in the average duration of absence for each of these causes would substantially reduce [sickness] benefit costs, opportunities for action should not be neglected. These might include:

1. Informing the personal physician more fully on the type of work to which the employee may return.
2. Willingness on the part of supervision to make reasonable adjustments in job assignments where indicated.

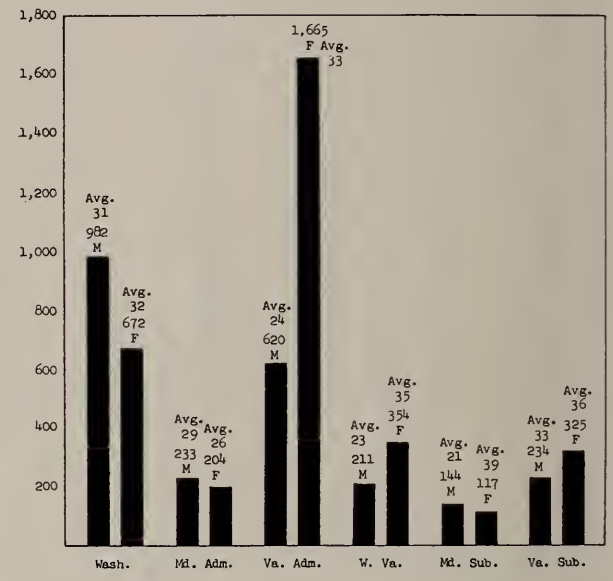


Chart 9. Total and average days—hemorrhoidectomy.

3. Willingness to put the employee back to work on any day of the week and, perhaps, earlier than had been anticipated.
4. Making sure the employee feels his work is important and he is needed on the job.
5. Assuring the employee that he is missed."

Here, by way of example, is a typical case history and in the words of one of our own company examining physicians, the problem and the all-too-frequent and unsatisfactory answer is revealed:

The patient is a thirty-one-year-old telephone operator with nine years of service absent from duty since March 29, 1960 and sent to our local examining physician on May 19, 1960, with this question being asked by the supervisor: "Are there any medical reasons why this employee can't return to work? Employee absent since March 29, 1960 and her personal physician advised us she will not be able to return to duty until July 1, 1960."

The examiner's summary report is as follows:

This thirty-one-year-old employee states that she had been having menorrhagia for three months prior to March 30, 1960. She had been under the care of Dr., gynecologist. On March 30, Dr. did a hysterectomy. Five

years ago she had a uterine suspension for dysmenorrhea and was away from work for sixty days. Since her operation on March 30, 1960, she states she has been quite nervous and generally upset emotionally. She states she does not feel well enough to return to work and her physician, Dr., has agreed that July 1, 1960, would be the appropriate time for her to return to work. She says she might feel well enough to return to work before this date, but she is unable to decide this at this time. Her psychosomatic history in the past is entirely normal. Childhood was adequate, and married life is well adjusted and

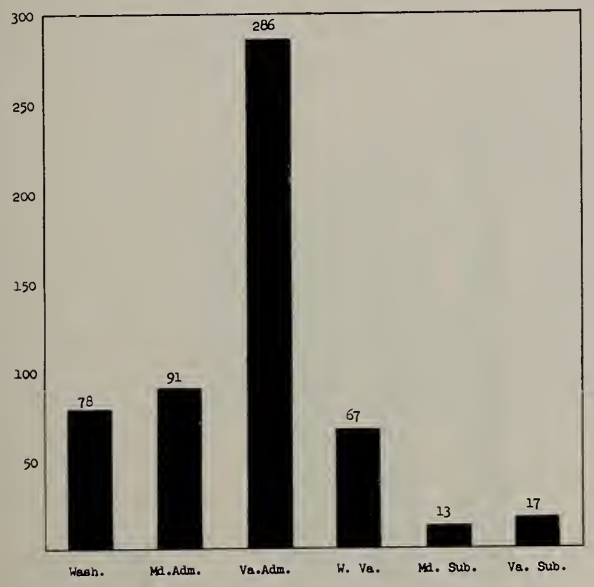


Chart 10. Number of cases—dilation and curettage.

happy. Review of systems is otherwise negative. I telephoned Dr. and he stated that July 1, 1960, was set as an outside time for her to return to work, and *we will have to depend upon how the patient feels.* Except for the objective complaints, the physical examination is entirely within normal limits. *I have no specific recommendations as to the time she should return to work.*

It appears obvious that this case is one of an emotionally unstable employee who has had major, but uncomplicated, surgery whose absence has been prolonged by iatrogenic overlay. Neither her surgeon nor our examiner offer any answer regarding her return to work other than it "will have to depend on how the patient feels." This places all parties concerned in a weak position. No one has really taken a firm position. In the face of this—can *we* blame the patient?

The influence of the attending surgeon is revealed by Moss and Dohan who state that 64 per cent of patients return to work within 1 week of the time predicted by the surgeon in writing (the prediction was made on an average of 34 days prior to the predicted date). Thirty per cent (30 per cent) returned to work on the exact date predicted by the surgeon.

Soniat[5] strikes a strong note in his comment, ". . . . the proper attitude of the first physician who examines

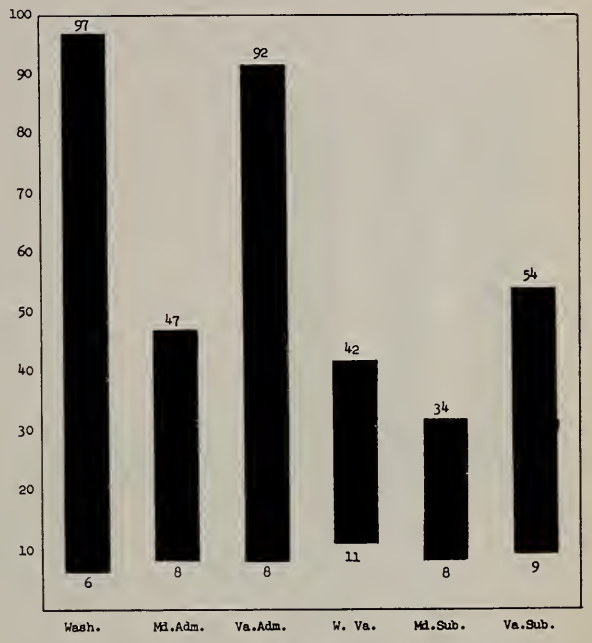


Chart 11. Range in days—dilation and curettage.

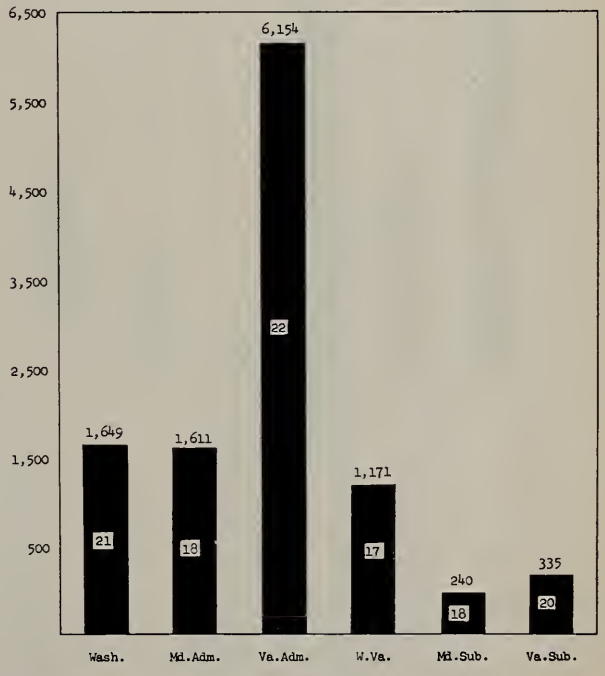


Chart 12. Total and average days per case—dilation and curettage.

the allegedly injured employee is an extremely important one that can be likened to that of the battalion surgeon who first sees psychiatric war casualties on the front lines, since his original attitude toward the patient and his technique in handling the situation

may mean the difference between return to efficient function or chronic invaldism of the one injured." Dr. Soniat made these remarks as part of his chairman's address before the Section on Neurology and Psychi-

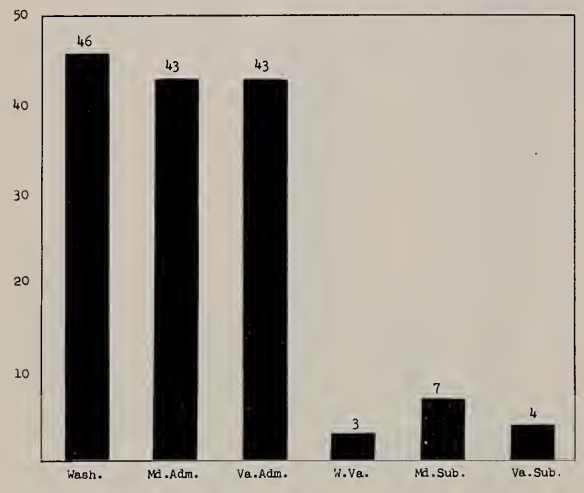


Chart 13. Number of cases—hysterectomy.

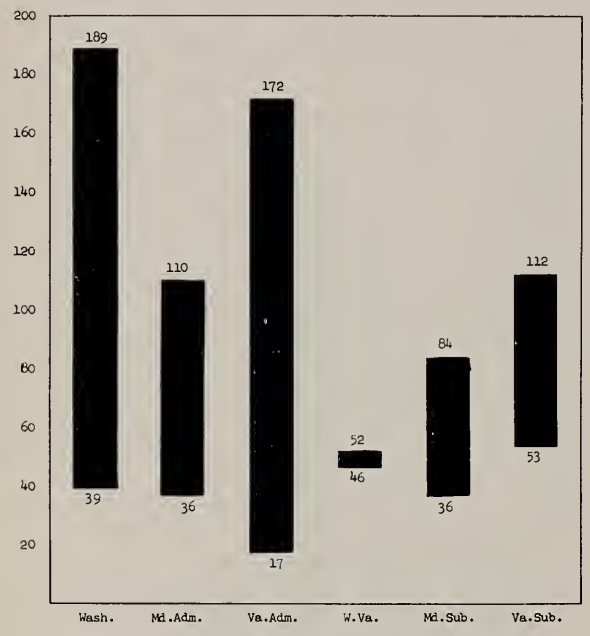


Chart 14. Range in days—hysterectomy.

atry, Southern Medical Association, in November 1959. The fact that he was discussing "The Problem of Compensation Neurosis" does not detract from the forcefulness and importance of his comments on the physician's role and would appear applicable in most patient-doctor relationships—and especially in the field of surgery.

Dr. John Davis, Medical Officer of our Maryland Company, has been interviewing employees who have had hysterectomies between January 1 and October 31, 1959. He has not completed his studies but answers thus far to two questions are particularly pertinent to this discussion:

1. *Based on how you yourself felt, when do you think you could have returned to work?*

12 answered "date returned"
4 answered "sooner" (1 said "may have")
1 answered "later—possibly"
3 answered "still felt unable to work"

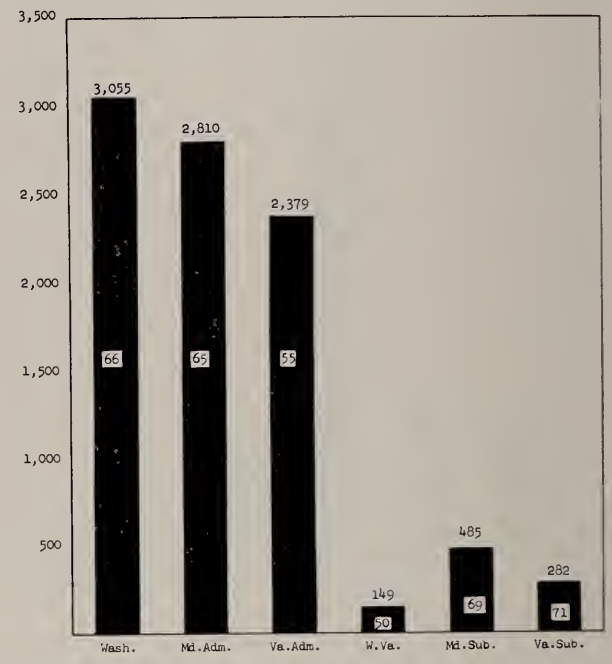


Chart 15. Total and average days per case—hysterectomy.

2. *Do you think you required a longer time or a shorter time to convalescence than indicated by your surgeon?*

3 answered "longer time" (1 said "possibly")
5 answered "shorter time"
11 answered "normal or adequate"

In the face of the foregoing, one cannot help but feel that the patient's surgeon exerts the strongest influence on when the patient returns to work. This is as it should be. Nevertheless, in the interest of all concerned, it appears that neither routine convalescent periods nor the patient's desire should be the prime motivating or determining factors in the length of absence. Patients should be individualized and not "routinized."

Various groups reveal that age and sex do not contribute to any major differences in length of convalescense. Patient motivation is of significance. Farmers generally return to duty earlier than insured employees and the self employed return far sooner than the employed.

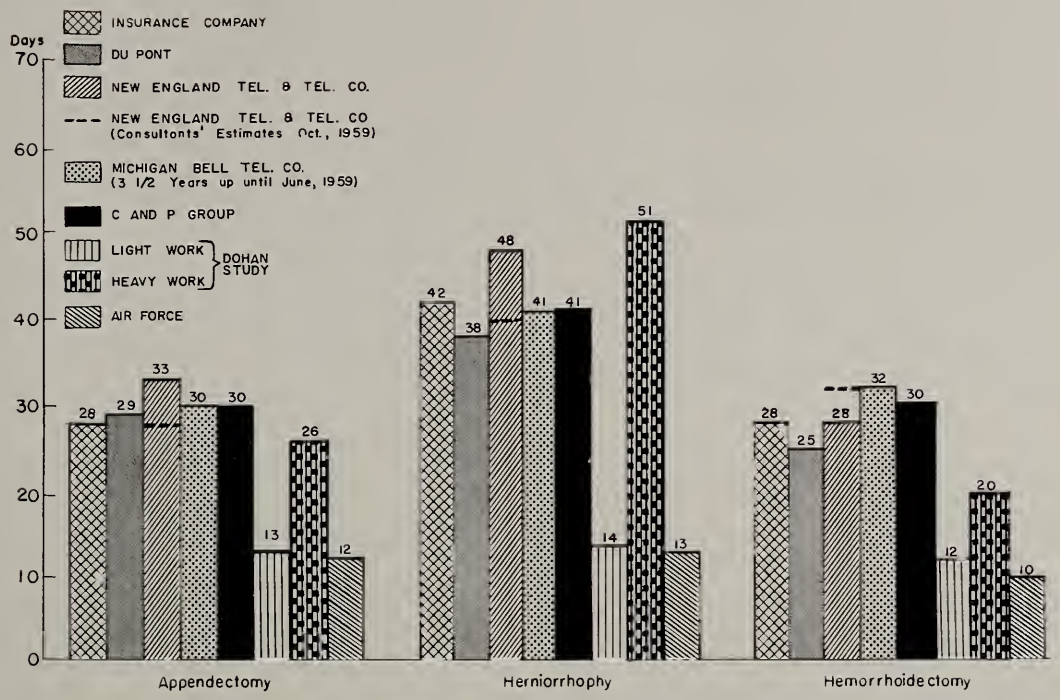


Chart 16. Average days of convalescence including men and women of all ages for appendectomy, herniorrhaphy and hemorrhoidectomy.

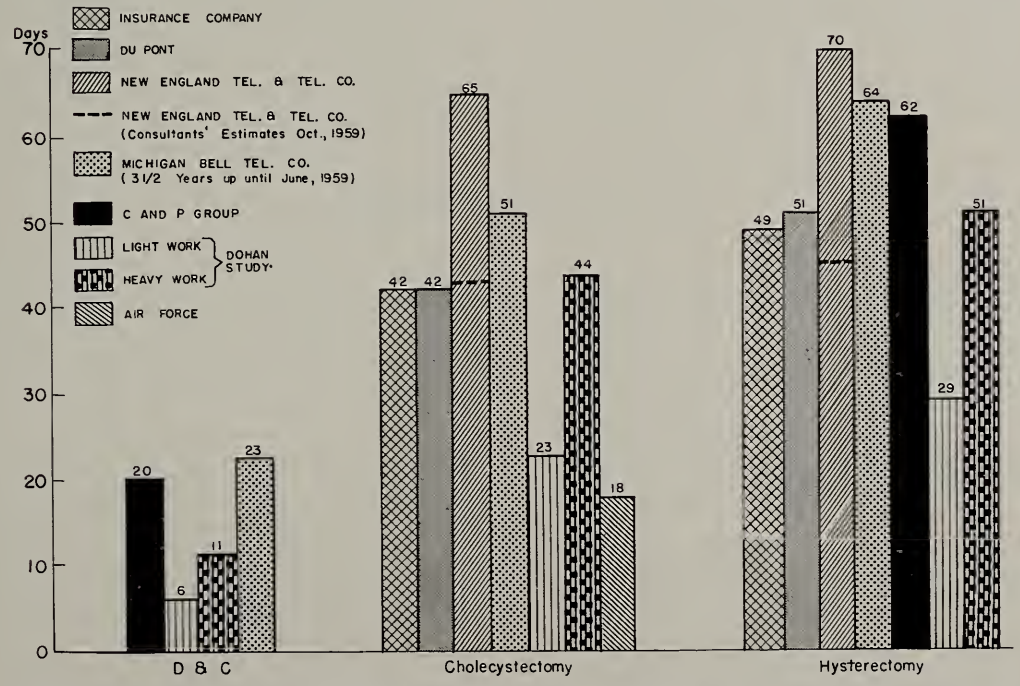


Chart 17. Average days of convalescence including men (cholecystectomy only) and women of all ages for dilation and curettage, cholecystectomy and hysterectomy.

Conclusions

1. A patient's motivation is a significant factor in length of absence from work following surgery.

2. Most people are ready to return to work physiologically much sooner than actually occurs on the average.

3. The most important factor in determining the length of surgical convalescence is probably the opinion of the surgeon.

4. Reduction by one-fourth in post-surgical absence among cases now running 4 weeks or longer would save industry and the worker approximately $46,080,000 a year.

5. The surgeon and personal physician can probably contribute greatly to the patient's peace of mind and emotional balance and earlier return to work if they take the time to explain the nature of the surgery, what it means, and what can be anticipated.

6. Programs to improve our experience will be some time in showing real improvement, for much education is needed among all groups involved. The industrial physician's approach to the employee's surgeon will require the utmost tact and patience.

7. Continuing study is needed to strengthen and reinforce the position of the surgeon with his patient and the position of the employer with his employee as it relates to prolonged convalescence following uncomplicated surgery.

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The Mentally Retarded

Mentally retarded persons achieve a much greater degree of out-of-school success than is commonly realized, and many of them manage to function as workers without benefit of special training. This and other findings are presented in a section on "The Mentally Retarded" in the July-August issue of *Rehabilitation Record,* just published. The magazine is the official publication of the Office of Vocational Rehabilitation.

Earning capacity and social adjustment of the retarded are highlighted in several articles. One, reviewing results of a project conducted by Goodwill Industries of Greater Kansas City (Missouri), notes that 62 "last hope" clients who were placed in jobs by Goodwill earned $64,558.91 and paid $3,704.80 in withholding taxes during the first two years of the project. The need for attacking problems of the more severely retarded by combining resources of vocational rehabilitation services, public schools and sheltered workshops is stressed in another contribution. How professional research and training needs and the social and vocational rehabilitation needs of retarded students are served simultaneously at New Jersey's Edward R. Johnstone Research and Training Center is detailed in an article by the Center's superintendent and three staff members.

NOTE: Single copies of *Rehabilitation Record* may be obtained for 30 cents from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. A year's subscription is $1.75.

Drug Addiction

Some Considerations of Attitude in the United States and Abroad

Max Warren, M.D.
Detroit, Michigan

WHILE abroad in 1959, I visited two countries in which I had an opportunity to observe approaches and attitudes toward narcotic addiction problems.

In Denmark, I visited the Bispebjerg Hospital, a large institution reminiscent of one of our county general hospitals. As in many such installations, my informant Dr. Mogens Nimb explained, a walk to the psychiatric pavillion is a long one, for usually it is the newest building, and the most outlying one.

Dr. Nimb works with Dr. Clemmesen in an acute psychiatric service comparable to that of one of our big city hospitals. A comparison of Denmark's addiction problem with our problem is of interest. Denmark has a population of 4.5 million. Roughly one-fourth of the population lives in Copenhagen. We can see that Denmark's population is less than that of Michigan. Its population is relatively homogeneous. Denmark is recognized for its interest in social welfare and for the medical care provided through national health insurance for most segments of the population. It has compulsory health insurance.

Dr. Nimb pointed out that Denmark's narcotic addiction is recognized as a medical rather than as a legal problem. Although he was interested generally in narcotic addiction, his primary interest was in barbiturate addiction, which he described as a serious wide-spread public health problem. There is a high incidence of barbiturate overdosing in attempted suicide.

It is not against Danish law to be an addicted person. It is against the law for anyone to give his physician the wrong name or address. Consequently, addicted citizens who attempt to get prescriptions for narcotics by giving erroneous information are liable to a jail sentence—not for addiction, but for giving misinformation bearing upon health welfare.

Dr. Nimb pointed out that under the Danish Medical Insurance Plan, each person has his choice of physician, and a change in this choice may be made only one time during a calendar year. This, of course, means that the addict is much more restricted in his sources of supply through medical channels. Illegal source of supply in Denmark, to the knowledge of medical authorities, is not significant. The scant supply of non-medical narcotics also lends to an easier control problem.

In addition to the limitation of the physician as a narcotic source, there is a further control. All prescriptions under the compulsory health insurance act must go to a central registry. In a Nation the size of Denmark, and with a density of population such as Copenhagen's, it is not too difficult a matter to check on prescriptions and the amount of morphine used.

Dr. Nimb pointed out the high relapse rate in addicted persons, and stated that most addicts left the hospital before a month of treatment was completed, much before adequate time for rehabilitation had elapsed. The absence of symptoms after physical withdrawal and the underlying psychic structure of the addicted person, tend toward a too-early stopping of treatment, a development which seems typical of the addicted person generally.

Bispebjerg Hospital and the psychiatric unit I visited have a world-wide reputation in an interesting and important area: Treatment of the patient who has attempted suicide. The special "Intoxication Center" as it is called, through research, round the clock service, requiring all drug intoxication patients to be treated in one center and using posture beds, tracheal intubation, fluid replacement, antibiotics, and renal dialysis, in a ten-year period reduced mortality figures in attempted suicide from 24 per cent to 2.3 per cent—a tenfold reduction.

The intoxication service is very expensive to maintain, the average per bed cost being six times the cost of the regular hospital bed. Nevertheless, research funds and dedicated work have succeeded in making an impressive change in the mortality figures.

Dr. Nimb pointed out that his country looked to the United States for research in narcotic addiction, particularly insofar as it seems to be a much more

pressing problem in the United States than it is in other western nations.

In England, the addiction problem was discussed with Mr. A. L. Dyke, His Majesty's chief inspector for the division of dangerous drugs, a branch of the A-1 division of the British home office. The A-1 division has other duties, including the administration of the Channel Islands.

Mr. Dyke, with the aid of four inspectors, carries out for all of England duties analagous with those of the Federal Government's representatives for the Michigan-Ohio District. The work also includes educational talks to police officers on narcotic addiction, inspection of chemists and wholesale sources of the drug, and liaison with the medical society in cases of physicians contributing to the addiction of a patient in lieu of attempting hospitalization and treatment measures.

Again, one was struck by Mr. Dyke's emphasis that his country looked upon narcotic addiction as a medical problem rather than a criminal problem. It is not a crime to be an addicted person in England.

Mr. Dyke called attention to the best survey of the British administrative handling of narcotics problems which has been done to date. He referred to the excellent report of Dr. Larimore and Dr. Brill, prepared in 1959 for Governor Rockefeller, from an on-the-spot survey which looked behind the written regulations and carefully considered the actual handling of narcotics problems.[1]

I did not sense the punitive attitude toward the addict which I find at home. Perhaps this is, in part, due to the close association between addiction and criminal activity in this country—the latter might be used, in part, to attempt to justify the predominant emphasis on apprehension and conviction. An improvement would be an expenditure on a medical and research approach at a local level, in addition to the very necessary enforcement activities.

Our national experience with narcotic addiction has been summarized in a recent U. S. Treasury Department Bureau of Narcotics pamphlet in which two principal solutions for the prevention and control of illicit narcotic activities are recommended. The first is compulsory hospitalization, with emphasis on state and local contribution of facilities and personnel. The second is effective policing.[4]

The experience of the City of Detroit Out-Patient Narcotics Clinic underscores some of the problems which arise when local facilities for long-term hospitalization and rehabilitation are not available.[2] The addicted person who seeks help is forced into withdrawal treatment which tends, in the mind of the addicted person, to minimize and over-simplify the nature of his illness and the need for rehabilitation and follow-up care.

In contrast to the use of distant facilities, local treatment would offer more immediate availability of treatment, increased opportunity for social and psychological services, counseling with family and relatives of addicted persons, and improved after-care. The special problems of hospitalization for narcotic addiction are well described by Dr. Herbert A. Raskin:

> "A narcotics addiction rehabilitation hospital must be a highly specialized treatment facility. It is to deal with a narrowly defined problem existing within a specific constellation of emotional construction. It requires extremely close supervision as to ensure a completely drugless living environment. A specially trained and oriented staff of doctors, nurses and attendant personnel is required to meet the myriad problems of acute withdrawal, physical and psychological rehabilitation, and psychological and social reorientation. The mere physical aspects of hospital construction must likewise be specifically dictated because of the longtime duration of hospitalization and the widely inclusive activity program of rehabilitation."[2]

As to the number of addicted citizens, the official census of drug addicts in England estimates a chronically addicted group numbering 350. Compare this number to the 714 addicted persons contacted by the City of Detroit Out-Patient Narcotics Clinic in a three-year period.

Wherein is the British system so different from the American? In the United States, one reads of the difference in attitude between the British system and the American system, citing the relative freedom of the British physician to prescribe narcotic drugs. In actual practice, as Larimore and Brill point out, and as Mr. Dyke substantiated, narcotic addiction in Britain is conceived as being a medical problem but there are limits to the discretion of the attending physician. If a doctor wishes to give an addicted individual a maintenance dose for addiction in an emergency on one occasion, that is one thing, but continuation of outpatient treatment without an attempt at withdrawal and hospitalization is seriously regarded by the British.

Mr. Dyke said, that in the latter event, the medical society would be notified of the doctor's indiscretion and the doctor would be called before the local medical society where his colleagues would, among other expressed views, say to him, "Look here old boy, do you think this is really proper treatment?"

To return to the report of Larimore and Brill, the British medical control of addiction is the result of the favorable British situation, and not the cause of it.

Many press reports in this country refer to the British system of narcotic control. The British object to the term "system," since they feel that the nature of their problem and what they consider to be a simple collection of administrative practices does not justify the designation "system."

As an instance of the importance of looking beyond administrative regulations to actual administration, let us look at an example given by Larimore and Brill: In Appendix IV of the British home office publication "Duties of Doctors and Dentists under the Dangerous Drugs Act and Regulations," the following precautions in the treatment of addicts are suggested:

> In the preceding section, the conclusion has been stated that morphine or heroin may be properly administered to addicts in the following circumstances, namely: (a) where patients are under treatment by the gradual withdrawal method with a view to cure, (b) where it has been demonstrated after a prolonged attempt at cure, that the use of the drug cannot be safely discontinued entirely on account of the severity of the withdrawal symptoms produced, (c) where it has been similarly demonstrated that the patient while capable of leading a relatively useful and relatively normal life when a minimum dosage of the drug is regularly administered becomes incapable of this when the drug is entirely discontinued.

On the surface of it, this is in striking contrast to the appropriate section of the U. S. Treasury Department's narcotic regulations based on the Harrison Narcotic Act and as interpreted by the U. S. Courts (U. S. Treasury Dept., Regulation No. 5, Article 167):

> A prescription in order to be effective in legalizing the possession of unstamped narcotic drugs and eliminate the necessity for use of order forms must be issued for legitimate medical purposes . . . courts have construed that prescribing for an addict to maintain his customary use is not a legitimate purpose.

However, as Larimore and Brill point out, the differences which appear to be so striking when laws and regulations are compared become much less significant when the narcotic control systems of the two countries are examined at the operational level.

"Duties of Doctors and Dentists under the Dangerous Drugs Acts and Regulations," the British home office memorandum, draws upon the 1926 Rolleston Report. The actual narcotic control administration carried out by the home office is based more nearly on the section of the home office memorandum, which reads as follows:

> The authority granted to a doctor or dentist to possess and supply dangerous drugs is limited by the words so far as may be necessary in the exercise of his profession. In no circumstances may dangerous drugs be used for any other purpose than that of ministering to the strictly medical or dental needs of his patients. The continued supply of dangerous drugs to a patient solely for the gratification of addiction is not regarded as a medical need.

In England, no special blank is required for narcotic drugs, and no special license or permit is needed by physicians or dentists in order for them to be able to prescribe narcotic drugs. With the exception of this aspect, there is striking similarity between narcotic drug administration in the United States and in England.

Under the National Health Act, regional medical officers act in an advisory capacity to physicians. Physicians are not required to report addicts to the regional medical officer. It is encouraged that any physician treating an addicted person secure psychiatric consultation or send the patient to a hospital or closed-service ward for in-patient treatment. This is very much in keeping with standards of practice in the United States, and hardly substantiates reports of easier access to maintenance dosages of drugs which (one gains the impression from this country's press) is the rule rather than the exception in Britain.

In Britain, there is no formal registry of addicts which provides addicts with an identification card enabling them to obtain narcotics at will from physicians. Nor are there any narcotic clinics operating in England to which addicts may report for drugs.

Narcotic addiction is virtually no problem in the British system, and there is little connection between crime and narcotic addiction in England. In 1954, out of a prison population of 40,000, there were only twenty-four addicted subjects. Penalties for peddlers and pushers are severe by British standards. The minimum is two year's probation, and if indicted and convicted, a fine of 1000 pounds and jail sentence may be meted out.

Larrimore and Brill, in evaluating which of the British methods might be applicable in the United States, stress the cultural differences, differences in the medical care system, and the aspect of criminal association with addiction in this country. Nevertheless, they suggest the following items which might merit a trial:

1. The British emphasis on the education of the physician and other members of the health education profession regarding the narcotic drugs and their use and handling.

2. The British insistence on semi-annual inspections of all chemist shops.

3. Maintenance of addicts on stabilized dosages. In regard to the maintenance of addicts, Larimore has the following to say: "While we were unable to get a definite answer to the question of whether it is possible to carry a narcotic addict along satisfactorily in a stabilized maintenance dose, it is of sufficient importance to warrant our studying on a research basis a group of addicts under rigidly controlled conditions to see if a stabilized maintenance dose is possible and desirable under certain circumstances. This does not mean that even if this proved possible under controlled study conditions, it should be applied full-scale on a community-wide basis. It must be remembered that in England, under the National Health Service, a patient (except in a real emergency) can go only to the one physician to whose practice he belongs; to secure drugs from more than one physician at a time is hard to accomplish. Thus, in this country, some effective means would have to be found to prevent addicts from obtaining drugs from more than one source.

In this country, specifically in the Detroit area, a sample monthly report of the local narcotic bureau revealed 203 heroin users and only twenty-three persons addicted to other types of drugs including morphine, methadon, and demerol. Inasmuch as heroin is not an approved narcotic in the United States, this means the preponderance of apprehended addicts obtain the drug through illegal channels. These figures would seem to underscore the association between criminal activity and narcotics in this country, a situation which does not exist anywhere near this extent in other countries in Western Europe.

The association of addiction with criminal activity leads to a necessarily stringent enforcement of existing regulations. At the same time, the association of addiction with criminal activities tends to blur the characteristics of the addicted person, such as low frustration tolerance, intense anxiety, a sense of urgency, and feelings that environment, friends, and family are obligated to relieve these feelings.[3]

The association of addiction with criminal activity tends to make many react with increasing punitive measures to the point where capital punishment for selling narcotics has been proposed in this country as a deterrent.

Abroad, the attitude toward addicts is not fraught with *our* fabricating a "crash program" and *our* punitive attitude. Addicts are not non-medical problems, but are treated as suffering patients in local medical and psychiatric facilities.

Contrast this humaneness with the attitude, that being addicted is in itself a crime to be primarily treated in a punitive fashion, so that more facilities are available for apprehension and conviction than for treatment.

Essentially, a legal, rather than medical, approach to the problem of addiction is of strictly limited helpfulness. This orientation does not imply a diminution of police vigilance but provides equal opportunity for treatment and apprehension and hospitalization.

In this connection, Dr. John M. Dorsey, Chairman of the City of Detroit Mayor's Committee for the Rehabilitation of the Narcotic Addict, strongly urges the following total approach to this grievous public health concern:

1. Local compulsory hospital treatment for the addicted citizen. (Ambulatory and "distant-hospital" treatment are inadequate).
2. Adequate legislation enabling compulsory psychiatric in-patient followed by out-patient treatment.
3. Active local out-patient follow-up treatment.
4. Community, school, and family psychiatric help for the addicted citizen and for each member of his family.
5. Powerful public health education program forcefully directed at preventing and eliminating drug addiction.
6. Continuing governmental vigilance devoted specifically to the prevention and elimination of drug addiction.
7. Closest possible cooperation of legal, law-enforcing, and public health agencies.

Acknowledgment

The author wishes to express appreciation for the helpfulness of Dr. John M. Dorsey, Professor and Chairman of the Department of Psychiatry, Wayne State University, and Chairman of the Mayor's Committee for the Rehabilitation of Narcotic Addicts.

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Report of Hysterectomies Performed at Sinai Hospital of Detroit 1953-1959

Joseph Stern, M.D.
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THIS REPORT concerns all of the hysterectomies performed at Sinai Hospital of Detroit in the seven-year period since its inception in 1953.

Sinai Hospital is a private, general hospital having 250 beds (until January 1, 1960) which devotes twenty of these beds to gynecology. The staff members of the Department of Obstetrics and Gynecology all have had formal training and all are either certified by the American Board of Obstetrics and Gynecology or are eligible for certification.

In this rapidly growing department, the number of hysterectomies has steadily increased from 147 in 1953 to 254 in 1959.

There has been a total of 1,329 hysterectomies performed over the seven-year period, 25 per cent of these having been done vaginally (Table I).

Perusal of Table I reveals that for the past two years (1958 and 1959), 30 per cent or 140 of 461 hysterectomies were performed by the vaginal route. Most of these were combined with anterior and posterior colpoperinorrhaphies.

TABLE I. HYSTERECTOMIES PERFORMED AT SINAI HOSPITAL OF DETROIT
From 1953 to 1959

Year	Number	Abdominal	Vaginal	
			No.	Per Cent
1953	147	124	23	(16)
1954	164	137	27	(16)
1955	174	132	42	(24)
1956	195	150	45	(23)
1957	188	151	37	(19)
1958	207	144	63	(30)
1959	254	177	77	(30)
Total	1329	1015	314	(24)

TABLE II. HYSTERECTOMIES PERFORMED AT SINAI HOSPITAL OF DETROIT FROM 1953 TO 1959
Report of First Seven Years

	1953	1954	1955	1956	1957	1958	1959	Total	Per Cent of Total
Leiomyomas	80	105	85	98	107	103	151	729	(55)
Cystocele and/or rectocele and/or prolapse	24	23	42	51	30	49	49	268	(20)
Adenomyosis	6	5	11	9	7	4	7	49	(3.6)
Pelvic inflammatory disease	10	3	9	8	8	7	4	49	(3.6)
Endometriosis	11	2	4	5	5	9	2	38	(2.8)
Carcinoma of endometrium	3	5	3	1	9	8	10	39	(2.8)
Dysfunctional uterine bleeding	1	5	1	6	2	7	8	30	(2.2)
Ovarian cysts—malignant and non-malignant		5	5	7	7	6	1	31	(2.2)
Carcinoma-*in situ* of cervix	5	1	3		2	4	6	21	(1.5)
Sarcoma of uterus		2	1				2	5	
Endometrial hyperplasia	1	2	3	4	6	2	1	19	(1.5)
Myometrial hyperplasia		1		1	1			3	
Chronic cervicitis	1	1	3	2	1	2	5	15	
Obstetrical complications		1				1	2	4	
Miscellaneous									
Hematometra			1					1	
Tuberculosis of pelvis						2		2	
Retained placenta					1			1	
Endometrial polyp	2	1	1			1		5	
Uterine perforation	1							1	
Congenital anomalies	1		2			1	1	5	
Squamous metaplasia of cervix				1				1	
Traumatic cervical stricture				1				1	
Uterine trauma					2		1	3	
Adenocarcinoma of colon or breast				1			2	3	
Carcinoma of fallopian tube		1	1						
Total	146	164	175	195	188	205	254	1327	(95.2)

Indications

Consideration of the indications for hysterectomy provokes much interest.

A glance at Table II shows that leiomyomas and uterine prolapse (with and without cystocele and/or rectocele) accounts for 75 per cent of all hysterectomies performed.

Endometriosis and adenomyosis accounts for 6.4

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per cent of the total. One might expect this percentage in a hospital practice composed primarily of private patients of the upper middle social strata.

Only 1.5 per cent of the hysterectomies were done for cervical carcinoma-in-situ; 5.6 per cent were done for various malignancies of the female genital tract.

Forty-five per cent of our patients are Jewish. Nine per cent are Negro.

Further Observations

Six per cent of all hysterectomies done were operated by the attending general surgeons.

In this connection, from the years 1955 through 1959, twenty-six supracervical hysterectomies were done for reasons other than obstetric. Of the twenty-six, nineteen (73 per cent) were performed by the General Surgical Staff.

The four obstetric complications that arose requiring emergency hysterectomies were two uterine ruptures, one placenta praevia accreta and a post-Cesarean Section uterine atony. Six other hysterectomies were done at the time of section but these were not performed for obstetric reasons.

The ages of the patients varied from nineteen to eighty-two years.

Of the 1,324 patients, one patient succumbed in the immediate postoperative period. Her's was termed an anesthetic death. There were no other postoperative deaths.

Summary

1. One thousand three hundred and twenty-four hysterectomies performed at Sinai Hospital of Detroit since its inception are reported.

2. During 1958 and 1959, 30 per cent of hysterectomies were performed via the vaginal route.

Poison Control Centers

The number of poison-control centers affiliated with the National Clearinghouse for Poison Control Centers rose to a new high of 460 as of July 1, Surgeon General Luther L. Terry has announced.

"That the poison-control center fills an urgent and widespread need is evident from the rapid growth of the movement since the first one was established in Chicago in 1953," Dr. Terry said. "It is also interesting to note that the movement was started by practicing physicians, in this case pediatricians, rather than by public health agencies. It was centered and coordinated in the Public Health Service in 1957 on the recommendation of the physicians operating the individual facilities."

The National Clearinghouse for Poison Control Centers serves local centers by providing information on new products which it obtains through a voluntary arrangement with manufacturers. Over 200 major producers of drugs and household products inform the clearinghouse of the ingredients in their products and antidotes for them. The clearinghouse is directed by the PHS Division of Accident Prevention, headed by Assistant Surgeon General A. L. Chapman.

"Because many parents do not recognize the poisonous qualities of many common products, they sometimes delay too long before calling a physician," Dr. Chapman said. "Many serious consequences of poisoning could be prevented if parents called physicians promptly," he added.

Aspirin tops the accident list for fatalities to small children. About 50 per cent of substances swallowed are medications. Some other common harmful products that are swallowed are kerosene, bleaches, detergents, soaps, waxes, polishes, lighter fluids, cosmetics, insecticides, and herbicides.

The centers maintain records of ingredients of trade-name products plus antidotes. This information is available to physicians by telephone day or night. Parents who call the centers are given first-aid instructions and are advised to call their doctor.

The Hazardous Substances Labeling Act, when in full operation, should facilitate the work of the poison-control centers. The new law, enacted by Congress last year and administered by the Food and Drug Administration, requires that safety information be given on labels of household chemical products, including the identity of hazardous ingredients, antidotes for toxic substances, and warnings and precautions needed for safe use. Requirements for labeling other hazardous articles are scheduled to go into effect February 1, 1962.

Under the new law some of the information now available only through the poison-control centers will be required on labels. This, however, will not reduce the need for the medical consulting services supplied by the centers. Many accidental poisonings are caused by consumers' disregard of label information, or by unlabeled substances and, most frequently, by leaving hazardous articles within the reach of small children. It has been estimated that annually 600,000 children swallow household aids left within their reach and that about 500 die as a result.

Retroperitoneal Lipomata

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RETROPERITONEAL LIPOMATA are fairly uncommon, although not rare, and a sufficient number of cases have now been recorded to permit a description of pertinent diagnostic points. These so-called retroperitoneal lipomata hold a special position in the group of fatty tumors, having a benign beginning both grossly and microscopically, only to show a marked tendency toward sarcomatous degeneration. In view of this inclination, it is our impression that all retroperitoneal lipomata of considerable size should be surgically excised as soon, and as completely, as possible.

Retroperitoneal tumors, by reason of the location and extent when detected, present many diagnostic possibilities and at times are approached with less aggressiveness than their true nature warrants.

These tumors grow very rapidly and attain enormous size; some tumors become malignant and recur locally after surgical removal. The true growth capacity of the tumors cannot be detected grossly, since metastases to the liver and lymph glands are rare.

Originally, lipomata were regarded as being uniformly benign. In 1857, Virchow was the first to describe the malignant degeneration of lipomata. The collective review of Von Wohlendorf[26] in 1921 again stressed the sarcomatous changes in retroperitoneal tumors. In this large series of 168 collected cases, 14 per cent were proven examples of liposarcoma. In 1950 Farbman,[11] covering a period of ten years (1937 to 1947), reported fifty-three cases in which 47 per cent showed malignant changes.

Farbman,[11] in a review of the literature from 1921 to 1927, estimated that seventy-six cases were reported, constituting a total of approximately 300 cases to 1947. Since that time, additional cases have been reported by Paul,[10] DeWeerd,[5] Cattell,[2] Noehren,[9] and others.

These tumors, because of their predilection to appear in the lumbar and pelvic area, along with their huge intraabdominal size and rarity, present a true surgical problem which warrants discussion.

Case Report

A man, aged 52, was admitted to Mount Carmel Mercy Hospital on January 17, 1959, because of a mass in the abdomen, which had been detected one month prior by a local physician. His abdominal complaints had been merely discomfort from pressure symptoms with a weight loss of only five pounds over a year.

Examination revealed the patient to be of moderate stature with mild hypertension (blood pressure 160/90 mm. Hg) and a pulse rate of 72. A smooth, non-tender mass was palpated in the mid-abdomen. The liver, spleen and kidneys could not be palpated. A provisional diagnosis of a mesenteric cyst was rendered.

Complete blood count revealed only moderate anemia with a hemoglobin of 77 per cent and hematocrit reading of 39 cc. per cent. Total serum proteins were 7.45 gm. per cent with a normal albumin-globulin (A/G) ratio. Sedimentation rate was 14 mm. per hour with non-protein nitrogen and blood sugar readings within normal limits. Serum amylase was 8 Bodanski units and the serum lipase was also normal.

Barium enema rotentgenograms revealed a large compressing mass displacing the colon to the left side of the abdomen without evidence of obstruction (Fig. 1). Upper gastrointestinal series films revealed only marked lateral displacement of the small intestines to the right side. Intravenous pyelograms showed only moderate lateral displacement of the ureters. Complete hematologic, blood chemistry, and urinalysis studies were not enlightening.

On January 18 the patient underwent surgery using cyclopropane endotracheal intubation with curare. The abdomen was entered through a vertical left perimedian incision. On entering the abdominal cavity, it was noted that all of the small intestines had been displaced to the right side of the abdomen, and the colon to the left side, by a huge retro-

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peritoneal abdominal mass. The lipoma measured 30x16x11 cm., was yellowish in color with a grayish membrane, which revealed multiple fibrous tags of attachment. The tumor was approached through the mesentery of the descending colon, taking care to preserve the blood supply to the colon and



Fig. 1. Barium enema roentgenograms reveal the huge retroperitoneal tumor with displacement of bowel to the left side of the abdomen.

sigmoid, and also to identify the ureters and kidney. Following removal of the tumor weighing 4,500 grams, through sharp and blunt dissection, the peritoneum was closed and drains brought out through the left flank. The patient tolerated the procedure well and received 1,500 cc. of blood. The patient's postoperative course was uneventful, with ileus subsiding on the third postoperative day and serous drainage from the flank drain stopping on the seventh day.

The tumor on cut sections revealed a grayish-yellow surface. The yellowish mass, which weighed 4,500 gm. and with the largest specimen measuring 30x16x11 cm., was similar to adipose tissue which was interspersed by grayish-white fibrous tissue. There were small areas of brownish-yellow discoloration which appeared firmer in consistency (Fig. 2).

The final histologic diagnosis as given by Dr. Lawrence W. Gardner, pathologist, was: Huge retroperitoneal lipoma with zones of fibrous replacement and plasma cell reaction, fat necrosis and liquefaction of fat; no evidence of sarcomatous transformation.

Histogenesis

The etiology of retroperitoneal fatty tumors is as obscure as that of other neoplasms. More must be known of the function and behavior of the fat cell before we can understand the nature of this tumor. Wells[13] reported the result of extensive chemical analyses of huge retroperitoneal liposarcoma, and stated that fat-forming mesenchymal cells can, on occasion, produce a broad variety of different complex tissue. This observation may account for the unavailability of tumor fat for nutritional purposes in extremely emaciated patients with huge retroperitoneal lipomata.

It is believed by other investigators that liposarcoma originate in the pre-existing lipoma and that it is the direct result of a long-standing chronic irrita-



Fig. 2. The retroperitoneal lipomata weighed over 4,500 gm. and measured 30x16x11 cm.

tion and stimulation. Hoagensen and Krekbiel,[18] in attempts to substantiate their theory experimentally by repeated injections of benzopyrene subcutaneously in guinea pigs, produced lipomatous tumors of which 50 per cent were liposarcomata. Stout[25] believes, however, that although some liposarcomata develop from previous lipoma, the majority were actually malignant from the beginning in some small area of these huge tumors.

Lipomas, according to Farbman,[11] are more common in the female, with a sex ratio of one male to six females, and are observed most frequently between the ages of forty and sixty years. The growth capacity is very slow, usually attaining a considerable size before being detected by the patient. The weight of these tumors is extremely variable. The largest

neoplasm was recorded by Williams in 1935 and weighed 51 pounds.

The classification of retroperitoneal fatty tumors is best separated into two main groups: benign and malignant depending upon the presence or absence of sarcomatous change. In the malignant group, a variety of histologic types are classified by Stout, varying from true liposarcoma to lipomyxosarcoma, to fibrolipomyxosarcoma and other mixed variations. However, because of the nature of these benign retroperitoneal lipomata, the classification must be accepted with reservation for, as stated above, these fatty tumors tend to recur frequently and often with sarcomatous changes.

Two consistent gross features of these tumors must be considered: (1) the tumors in general were huge and bulky and showed evidence of being well encapsulated and (2) about one-third of the tumors have a smooth surface, but irregular contours with fibrous separated lobes.

The clinical diagnosis is usually difficult, insofar as the symptoms are generally meager and consist only of an abdominal mass. Farbman[11] states that, from their case studies, the average duration of symptoms before medical advice was sought was thirty-two months. Vague pressure manifestations are the usual early symptoms. However, with the advent of malignant degeneration, fatigue, weight loss, and anorexia may occur.

In 1921, Masson and Horgan[22] called attention to the usefulness of urographic diagnostic procedures, especially in distinguishing between retroperitoneal lipomata and intrinsic renal lesions. The major diagnostic point of the intravenous pyelogram is the tumor's effect on the position of the kidney. Ordinarily, an intrarenal tumor fails to displace the kidney, while an extrarenal neoplasm almost invariably shifts the renal outlines. In addition to displacement of the entire kidney, so-called renal torsion is of diagnostic significance. Weyrauch[24] has described this torsion as being about a vertical, horizontal, or transverse axis. Intravenous pyelograms are an aid in determining kidney functions if a nephrectomy must be performed at the time of surgery.

Differential diagnosis will be aided considerably by barium enema and upper gastro-intestinal series roentgenograms. Displacement of small intestines, colon and stomach without an intrinsic lesion indicates a tumor outside of the gastro-intestinal tract.

To recognize a retroperitoneal tumor pre-operatively as being a lipoma is a rarity. However, it must be considered along with other possible diagnoses of intra-abdominal masses such as pancreatic cysts, mesenteric cysts, abdominal carcinomatoses, splenomegaly, ascites, cirrhosis and pregnancy.

The only satisfactory treatment is complete removal of the tumor. If the tumor is encapsulated, the operation presents no particular difficulty. However, many lipomatous tumors are not encapsulated and present multiple ramifications. Because of the intimate association with retroperitoneal viscera, many patients will require nephrectomy (50 per cent according to McLaughlin and Sharpe,[23] and 14 per cent according to Pemberton and McCoughan[14]). This operation is necessary when separation of the tumor from the kidney is impossible, when the ureters or renal vessels are injured, or when a hydronephrotic kidney is present.

The hazards of surgical excision are considerable, and the mortality rate varies from 20 to 25 per cent. Special care must be exercised, therefore, to avoid injury to important blood vessels such as mesenteric arteries and veins, the abdominal aorta, inferior vena cava, and renal vessels. Accidents to these structures have resulted in fatal hemorrhages and gangrene of the intestine. Delayed postoperative complications, which contribute materially to the high mortality rate, include ileitis, peritonitis, gangrene of the intestine, pneumonia and pulmonary embolism. Consequently, every effort must be made to prevent these complications.

The transperitoneal approach with patient under spinal anesthesia affords the safest access to these tumors. The lumbar approach does not permit sufficient exposure to the mesentery of the bowel and retroperitoneal structures.

The use of high voltage roentgen ray therapy postoperatively in cases of malignant transformation has been of questionable value. However, irradiation may be employed for those patients proved inoperable by a thorough exploration.

If left untreated, the growth of these tumors leads slowly to death. Following excision, recurrence is common and malignant degeneration is frequent, but it is possible in many instances to excise the recurrent growth and extend life significantly. According to Farbman's series of cases of malignant fatty tumors, 55 per cent of the patients died within eighteen months after surgery. Approximately 43 per cent of the benign tumors had recurred in from seven weeks to five years and, of this number, about one-half showed malignant transformation.

Summary

This case is reported mainly because of the apparent scarcity of literature on the subject. The clinical recognition of retroperitoneal tumors is not easy, but should be considered in any patient who presents a huge abdominal mass attended by meager symptoms.

These tumors are most frequent in women between the ages of forty and sixty years, are prone to malignant degeneration, and are given to local recurrence following surgical excision.

The treatment of choice, despite these characteristics, is a thorough surgical attack.

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AMA *Resolution*

Following is the full resolution, as amended, passed by the AMA House of Delegates opposing the King-Anderson legislation:

The House of Delegates of the American Medical Association records its opposition to any legislation of the King-Anderson type. . . . Its opposition is based on the facts that such legislation does not meet the needs of the situation; interferes with the doctor-patient relationship; interferes with the rights of doctors employed in hospitals; is inordinately expensive; leads inevitably to further encroachments by government into medical care; results eventually in a deterioration of the type of medical care rendered the public; and is therefore detrimental to the public interest. . . . The House of Delegates invites attention to the fact that the medical profession is the only group which can render medical care under any system and that the medical profession is best qualified to determine how the best medical care can be delivered. . . . The House of Delegates believes that the medical profession will see to it that every person receives the best available medical care regardless of his ability to pay, and it further believes that the profession will render that care according to the system it believes is in the public interest and that it will not be a willing party to implementing any system which we believe to be detrimental to the public welfare.

Treatment of Tinea Capitis with Griseofulvin

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THIS REPORT summarizes the treatment with griseofulvin of 142 cases of tinea capitis seen in the Dermatology clinic of Detroit Receiving Hospital and thirteen cases treated privately by the author from July 1959 to July 1960. An additional sixty-four clinic cases could not be included because of lack of follow-up visits. The 206 cases represent the total of new cases seen in the clinic from July 1959 to March 1960, about twenty-five new cases each month. Bright greenish white fluorescence under the Wood's light was present in 147 of the treated cases. Of these, 145 were due to *Microsporum audouini* and two to *Microsporum lanosum*. Eight cases were non-fluorescent and were caused by *Trichophyton tonsurans*.

About 90 per cent of the patients were Negro. Boys outnumbered girls in a ratio of 7:1. The age distribution of 285 cases due to *M. audouini*, including additional cases seen in the clinic but not treated with griseofulvin, is shown in the accompanying chart.

While the effectiveness of griseofulvin for tinea capitis has been well established[1-3] there may still be some question as to the optimum dose. It was our purpose to find a minimum and yet still effective dose for infections due to *M. audouini* which is still the predominant organism in the Detroit area, although the number of cases due to *T. tonsurans* has been increasing. Our results with *T. tonsurans* and *M. lanosum* infections are summarized later in this report.

Summary of Treatment Schedules

These schedules apply only to *M. audouini* infections. In addition to the griseofulvin, patients were given a 3 per cent sulfur, 2 per cent salicylic acid cream to apply to the affected areas morning and night. They were also asked to cut the involved areas closely with a scissors, and to shampoo once weekly.

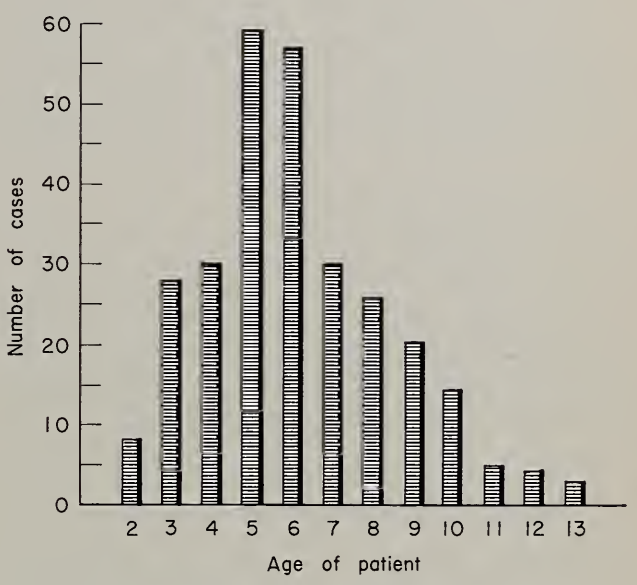


Fig. 1. Age distribution of 285 cases of tinea capitis due to *M. audouini*.

Patients were seen every two or four weeks. The criterion for cure was absence of fluorescence and regrowth of hair. An effort was made to see patients for three months after disappearance of fluorescence. However, the follow-up was far from satisfactory in this group and we are including as cured all cases that became negative under the Wood's light even though there was no subsequent visit.

In those cases that were cured, fluorescence usually became dull or was absent in four to six weeks, and was almost always negative at eight to ten weeks. If bright fluoresence persisted beyond ten weeks, it was felt that any subsequent cure should not be attributed to the griseofulvin.



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Griseofulvin (250 mg. Daily).—The results with sixteen cases are summarized in Table I.

In this group therapy was usually continued until there was dulling or absence of fluorescence. Hence, the higher failure rate in the group receiving medication from eight to thirteen weeks simply means that bright fluorescence persisted in the four failures despite continuation of therapy.

TABLE I. GRISEOFULVIN 250 MG. DAILY

Number Cases	Weeks Rx	Weight*	Cures	Failures	Weight of Failures	Failures+** at—Weeks
2	2	44, 50	0	2	44, 50	28, 28
1	3	30	1	0		
5	4, 5	26-50	5	0		
8	8-13	35-82	4	4	40, 61, 73, 82	12, 13, 13, 9

*All weights are in pounds.
**Brightly fluorescent (+) at stated number of weeks after onset of therapy; these figures correspond in order to the weights of the failures.

Griseofulvin (500 mg. Daily).—A total of thirty-five cases were treated (Table II).

Griseofulvin (1.0 gm. Daily for Two and Three Weeks Only.)—Sixty-one cases were given one gram daily for two weeks only, and eight cases were given one gram daily for three weeks (Table III).

TABLE II. GRISEOFULVIN 500 MG. DAILY*

Number Cases	Weeks Rx	Weight	Cures	Failures	Weight of Failures	Failures+ at—Weeks
8	2	39-81	6	2	58, 52	24, 12
16	4	35-75	13	3	45, 60, 60	21, 15, 11
1	5	60	1	0		
5	6	35-85	5	0		
4	8-10	36-60	1	3	53, 36, 48	18, 24, 24
1	13	50	0	1	50	13

*The explanatory notes for Table I apply for Table II.

Griseofulvin (Single Dose of 3.0 and 4.0 gm.)—Eight patients swallowed a single dose of 3.0 gm. in tablet form, and ten patients swallowed 4.0 gm. in the presence of the author (Table IV).

Miscellaneous and Mixed Dosages.—One 62-pound male received 1.0 gm. daily for one week only. He was non-fluorescent at six weeks. Two males, both weighing 38 pounds, received 750 mg. daily for two weeks. They were negative at eight and ten weeks. One boy, weight 39 pounds, received 1.0 gm. daily for two weeks and 0.5 gm. for one week. He was negative at three weeks. Six patients received 500 mg. daily for two weeks, then 250 mg. daily for two to six weeks. Four (weights 45 to 60) were cured, and two (weights 60 and 66) failed on this dose.

TABLE III. GRISEOFULVIN 1.0 GM. DAILY*

Number Cases	Weeks Rx	Weight	Cures	Failures	Weight of Failures	Failures+ at—Weeks
62	2	33-144	58	4	54, 62, 48, 40	24, 12, 12, 17
8	3	31-74	8	0		

*The explanatory notes for Table I apply for Table III.

Trichophyton tonsurans Infections

In view of the nationwide increase of tinea capitis due to *Trichophyton tonsurans* as reported by Gray,[4] Hill,[5] Georg[6] and others, our experiences with this group are reported in somewhat more detail. Eight cases were non-fluorescent. Cultures revealed *T. tonsurans*, seven of the sulfureum and one of the crateriforme type. These eight represented 3.9 per cent of the total. One patient had a very large kerion, three had widespread folliculitis, pustulation and crusting, and four had varying sized scaly areas without inflammation. Three had large areas of alopecia when first seen.

TABLE IV. SINGLE DOSES OF GRISEOFULVIN*

Dose (Grams)	Number Cases	Weight	Cures	Failures	Weight of Failures	Failures+ at—Weeks
3.0	8	40-73	5	3	41, 57, 51	13, 15, 13
4.0	10	41-98	6	4	54, 68, 60, 60	8, 20, 10, 12

*The explanatory notes for Table I apply for Table IV.

Four cases have been followed for a sufficient period to permit evaluation of therapy. One had a large kerion, and two had widespread pustules and crusting. Two, weights 58 and 64, received 1.0 gm. daily for seven weeks, and one, weight 54, 1.0 gm. daily for six weeks. In addition, wet compresses and antibiotic ointments were used. These three showed steady improvement. In from two to three months, infection had cleared, there was regrowth of hair, and repeat cultures were negative.

One four-year-old boy, weight 42, had numerous small, non-inflammatory scaly lesions scattered over the scalp. He was given 1.0 gm. daily for four weeks only. Three months after onset of therapy, there was considerable improvement but a few scaly lesions persisted, and culture was positive. Repeat cultures from scaly lesions at four and six months were still posi-

tive. He has recently been started again on a daily dose of one gram.

Microsporum lanosum Infections

Two brothers, weights 40 and 68, had bright fluorescent patches without secondary infection. Cultures revealed *M. lanosum*. Each received 1.0 gm. daily for three weeks, at which time fluorescence had disappeared.

TABLE V. BLOOD AND URINE DETERMINATIONS

Dose (Grams)	Number Patients Examined		Abnormal Findings
	Hb., WBC	Urine	
0.5 daily, 2-13 weeks	4	1	None
1.0 daily, 2 weeks	34	28	WBC 3,600 in one; albumin trace and 1-plus in one each, WBC's slightly increased in 3 urine
1.0 daily, 3 weeks	5	5	None
3.0 single dose	2	0	None
4.0 single dose	7	6	None

Toxicity

Hemoglobin determinations and total white blood cell counts were performed on fifty-two, and urinalyses on forty patients at some time during or after the course of medication. Eighty-five per cent of all determinations were made within six weeks after onset of therapy, the balance at a later time (Table V). There was no significant drop in the hemoglobin level in any patient. In only one was the total white blood cell count below 4,000. In patients receiving 1.0 gm. daily for two weeks, one had a trace, one a 1-plus albumin, and three males had a slight increase in white cells (6 to 16 per high power field) in the urine. In patients who received a single dose of 4.0 gm., one had a trace, and one had a 1-plus albumin in the urine. All other determinations of these measurements were within normal limits.

One patient apparently developed urticaria while on a daily dose of 0.5 gm. for two weeks, although the eruption was not seen by the author. Two complained of severe headache after taking a single dose of 4.0 gm. One of these had a previous history of migraine. In another, the 4.0 gm. was vomited.

Age Distribution of Tinea Capitis Due to M. audouini

In a previous report, Lewis and his associates[7] charted the age incidence of *M. audouini* scalp ringworm in 203 white and 72 colored children. They found a peak incidence in both groups at the age of 8, but there was a sharper drop-off beyond that age in the Negro children as compared to the whites. In our series of 285 cases, of which about 90 per cent were Negro, there was a sharp peak at the ages of 5 and 6. Part of the explanation may be that many previously undiagnosed cases were picked up by the school nurse at the time of the child's first admission to school, and also being put in a much larger group would enhance the possibility of communication. Nevertheless, only 16 per cent of our cases were 9 years of age or older. Rothman[8] postulated that the disappearance of tinea capitis due to *M. audouini* beyond the age of puberty is due to the changes in the character of the sebum which occurs at puberty. This viewpoint was questioned by Kligman.[9] In view of the sharp decrease in cases well before the onset of puberty, one would suspect that other factors, in addition to changes in the sebum, may be responsible for this event.

Comment

In the group receiving 250 mg. daily for three weeks or longer, six weighed less than 40 pounds and all were cured. Nine, weighing 40 pounds or more, received this dose for four weeks or longer. Of the nine, four failed. It therefore did not seem that this dosage could be depended upon to cure patients weighing over 40 pounds. More favorable results with a daily dose of 250 mg. were reported by Harrell.[10]

In the group receiving 500 mg. daily, eight took the medication for only two weeks. Two of these weighed less than 40 pounds and were cured. Six weighed 40 pounds or more. Of these, four were cured; however, two (weights 58 and 52) failed.

Twenty-seven received 500 mg. daily for four weeks or longer. Of the four weighing less than 40 pounds, three were cured and one failed. Twenty-three weighed over 40 pounds. Seventeen of these were cured, but six failed. We concluded that the failure rate on a daily dose of 500 mg. for those weighing over 40 pounds was still too high.

Our best results were obtained with those on 1.0 gm. daily for either two or three weeks. With 1.0 gm. daily for two weeks only, fifty-eight of sixty-two cases (94 per cent) were cured. Two of the four failures were encountered in brothers. The weight range of the fifty-eight cured cases was 33 to 144 pounds (average, 51). Ten weighed from 33 to 39 pounds.

Eight persons weighing from thirty-one to seventy-four pounds (average, 50) received 1.0 gm. daily for

three weeks only. Only one of these (weight 31) was under 40 pounds. All were cured.

The results with a single dose of 3.0 and 4.0 gm. were not too satisfactory, since three of eight patients given 3.0 gm., and four of ten persons receiving 4.0 gm., failed. Preliminary favorable results with a single 5.0 gm. dose were reported by Goldman.[11]

Spot checks of hemoglobin and total white blood cell counts on fifty-two, and urinalyses on forty patients failed to reveal any significant abnormalities. This supports the more careful studies of Livingood[12] as to the low toxicity of this drug.

Summary

One hundred and forty-five cases of tinea capitis due to *M. audouini*, two due to *M. lanosum*, and eight due to *T. tonsurans* were treated with oral griseofulvin.

For *M. audouini* infections, the main dosage schedules were 0.25, 0.5, and 1.0 gm. daily, and single doses of 3.0 and 4.0 gm. The failure rate for those receiving 0.25 or 0.5 gm. daily and weighing over 40 pounds was found to be too high. Results with single doses of 3.0 and 4.0 gm. were also not satisfactory. Best results were obtained with those receiving 1.0 gm. daily for two or three weeks. Fifty-eight of 62 receiving 1 gm. daily for two weeks, and all eight receiving this dose for three weeks were cured.

Four cases due to *T. tonsurans* could be evaluated as to therapeutic results. Three of these, all with inflammatory reactions, were cured with 1.0 gm. daily for six and seven weeks. One, a non-inflammatory type, relapsed after receiving 1.0 gm. daily for four weeks only.

Spot checks of hemoglobin, total white blood cell counts, and urinalyses in about one-third of the patients failed to show any significant abnormalities. Other clinical side effects were minor.

The age distribution of 285 cases due to *M. audouini* showed a sharp peak at the ages of five and six. Only 16 per cent of these were nine years of age or older.

Acknowledgments

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Use of Hearing Aids

About 1,161,000 of the civilian, noninstitutional population of the country have hearing aids, according to the Public Health Service's National Health Survey. This total represents one-fifth of the people who are reported to have hearing impairments.

Otolaryngology

The Section of Otolaryngology of the Michigan State Medical Society is grateful for the opportunity of presenting the scientific articles in this issue of the Michigan State Medical Society JOURNAL.

We believe the articles reveal some of the interesting, challenging, and rewarding work that is being done in the field of otolaryngology. The limitation to five articles prevented presenting a broader coverage of interesting work that has developed in this field such as reconstructive surgery of the tympanic membrane and middle ear; and the treatment of Ménière's Disease. Also significant progress in bronchoesophagology; nasal reconstructive surgery; and head and neck oncology. No doubt these phases will be covered in other issues of the JOURNAL.

It has been said otolaryngology is a dying specialty. Perhaps this was partially true for several years with the drop in surgery associated with infections. However, we are happy to report there is a revitalization of the specialty, as exemplified by the increase in number of applications of top caliber men for residency positions. This is, no doubt, due to the fine advances in surgery of the area and excellent research work that is going on.

Hence, in addition to hoping this issue proves interesting and informative to the physicians who read it, we have a selfish motive of hoping it stimulates the interest of some of our fine caliber interns in the specialty of otolaryngology.

V. E. CORTOPASSI, M.D.

Legislation We Can Support

Income Tax Benefits

Numerous proposals for the care of the aging, those over 65, have been proposed for the last four or five years. Many of them the medical profession could not support because of the included concept of socialized medicine, The Forand Bills, the old Wagner-Murray-Dingell Bills, the recent King-Anderson-Kennedy Bills, have been a little different approach, but all have involved the government's stepping into the practice of medicine which would provide service rather than indemnity or benefit payments.

George T. Kelleher, M.D., former MSMS delegate, and George W. Slagle, M.D., Past President MSMS and presently a member of the AMA House of Delegates, have worked out and proposed a plan which was presented to the AMA House of Delegates and unanimously approved. This plan will be introduced (has been) by Congressman August E. Johansen, third District (R-Michigan).

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Simply stated, the proposal is that the aging person over 65, or his tax-paying relative, after figuring up his income tax according to the present requirements, may deduct from it the amount he has paid for medical and hospital costs or insurance, such as Blue Cross-Blue Shield. Michigan's present senior citizen Blue Cross-Blue Shield policy, which was not increased by the recent rate adjustment, amounts to $203.28 per couple per year. The aging couple with an income of around $2500 a year would be paying about $210 in income tax. This reduction, providing they had Blue Cross-Blue Shield, would leave them a balance of $6.72 to be paid. This is a very definite and a very specific benefit to those of low income, whether on social security or not. This does not involve social security, but does provide for use of the voluntary insurance program.

There is precedent for this type of legislation. In the first place, there would be no need to set up a separate bureau. The actuarial precedent of the Federal Employees Medical Care Insurance program is an established premium base point. Privately purchased medical care insurance would allow the members of this group to obtain medical care without public surveillance of their illnesses and their privileged physician relations. It would avoid third party intrusion and control of medical situations. This is another bill which the medical profession can support without any reservations.

The AMA House of Delegates also approved HR 5223, a bill to allow tax exemption for all drugs and medicine purchased for persons 65 and older. This action is in recognition of the high costs of medical care for many senior citizens. Legislation of this sort is undeniably in the public interest.

Instead of offering a hospital service program hidden by an entirely unappropriate tax, these bills would recognize the patient's right for privacy. In addition, it would help financially, by a definite reduction of the income tax load for this group about whom President Kennedy has been worrying so much, but for which the King-Anderson proposals fail to include medical care except when offered under contract payment through hospitals.

The Keogh Bill

The Keogh bill has been proposed for 10 or 12 years, and almost passed twice. It would provide that self employed professional or business people who do not have a corporation to set up tax exempt endowments for their retirement, may set up their own tax exempt program. The self-employed would be able to set aside 1/10 of their income up to $2500 a year, before taxes. The object is to establish a retirement or old age fund.

This bill should be passed this time. It has failed by neglect and by non appreciation of need by certain members of Congress. Kipplinger and other news analysts have felt this bill would pass during this Congress.

Another bill the senior citizens and the medical profession could support would be a proposed amendment to the Social Security Act. It is badly needed. A small part was enacted by the last Congress. For years, there has been a prohibition of work for the beneficiaries of social security. If their income was over $100 a month or over $1200 a year, they lost the benefit for the months in which it exceeded a certain amount—approximately $80. The last Congress boosted that to $150 a month or $1800 a year. Congress should completely remove this restriction. Social security is insurance. If an insurance benefit has been earned, by what right does the government prohibit these senior citizens from benefiting, just because they were able to work a little bit longer than a specified maximum? Actually the government should be happy because every one of these people who work still contributes to this tax and to the social security program, not only his 3 per cent but his employers 3 per cent. Removing the limit and restriction on this benefit would help both the recipient and the tax-collecting bureaus of the government.

Running Scared

For the past 12 or 15 years, the world has been running scared. A dictator in far off Russia threatens to infiltrate our civilization and our government and provoke a third World War—a nuclear war which we are told would mean the destruction of civilization. The United States has been taught and has talked civil defense and our government has set up tremendous observation posts and defense mechanisms to discover attacks before they hit us, and how to care for ourselves afterwards. The main concept is fear that a nuclear war means the end of civilization.

The American people have only half heartedly accepted that philosophy, but we have spent billions of dollars trying to counteract it. It seems to us that it is time we as a nation make a resurvey. We have spent those billions all over the world attempting to build up friendships which often faded the minute we needed them. We believe the concept is much exaggerated. Hiroshima and Nagasaki underwent nuclear warfare. The destruction was tremendous, but those who survived proved that such an attack is not the end of civilization. We believe a complete about-face would disarm and disabuse the power which has been a threat. In our younger years, when a bully met a man unafraid who would stand against him, the bully usually disappeared. So much for world politics.

The medical profession has been running scared for about three decades. In the 1930's we had two fears. One was an enormous depression, where only a very few actually had sufficient income to be comfortable and most were working on depressed or reduced wages or none. The welfare department administrators stepped in—took charge of the indigent and especially the medically indigent. In Michigan, the administrators came in, decided what class and group of drugs could be used for our patients, how many visits we could make, and how much we could be paid for our services, if any. That was the State's economic program. We also had a group of do-gooders trying to change the laws and set up a nationwide and also sometimes a state wide compulsory medical service program. One or two of these bills were introduced, and some were narrowly defeated in California.

Medicine was concerned then by its need to care for our patients, also it feared that its liberty would be lost and the profession become a governmental bureau with bureaucrats dictating and administrators putting limitations on our services. Here in Michigan for many years, we fought the Wagner-Murray-Dingell bills. The medical profession justly earned the approbrium of being always against legislation and never suggesting anything constructive—"always against." In the 1940's, we recovered somewhat out of that fear. The Dingell bills were present and threatening, and the concept of the health and welfare department in Washington still kept the professon on the run by unmerited criticism, by reporting every uncomplimentary act that could be found, and by building up an anti-medicine picture in the public mind.

A philosophy of constructive legislation, proposals for public benefit which the profession could support, Senator Taft's medical care bill advocating prepayment, and the growth of successful prepayment plans followed, never opposing any legislation without a suggestion of something favorable. After several years, that concept disappeared and the profession almost forgot the threat of socialized medicine.

In this last political campaign, there was a definite change. It had seemed that the Forand-type legislation would be forgotten. Care of aging became a campaign issue. Those who favored the old-style compulsory insurance, the welfare workers, social workers, bureaucrats, began spreading the opinion among the general public that everybody in the older age limit was desperately poor and should be taken into the social security program for their medical and hospital care. About four million of those over 65 were acknowledged indigent, never had worked, and were the logical beneficiaries of the state welfare department. They were cited as examples of need. Obviously, they could not become beneficiaries of social security and never would. They were not eligible.

A percentage of those who are beneficiaries of social security and also in that low income group, will need attention. The Kerr-Mills Act was passed last summer to care for these and the four million indigents. It has been only partially allowed to take effect. The bureaucrats, and the socializers and labor were much disappointed with Kerr-Mills because it did not fit in with their concept of government taking over medicine. For that reason, during the last months of the campaign and since, the medical profession has been running scared, more or less fearful of losing our identity and becoming cogs in the governmental wheel.

The profession lived through the 30's and saved their individuality and independence. They also lived through the 40's successfully, primarily by establishing the prepayment medical and hospital plans and proving that through private enterprise the sick could be cared for without government intervention.

Now in the sixties, we are running scared again.

The opinion of the medical leaders, at the AMA convention, largely was that we can survive this threat of the sixties also. It is going to be much more of an effort than either of the others. The profession has labor forces against it, who are absolutely adamant against the AMA. They do not hesitate to use any means of misrepresentation, as amplified in their newspapers. The bureaucrats and socializers who are now back in the government are adding to that fear concept.

Too many in the medical profession have been bitten. We have one answer now available, *the medical profession must make its prepayment plans work.* We admit the plans cost more than in years past but the medical and surgical care today is so absolutely intricate, complicated and far advanced, calling for much technical and other assistance for expensive appliances, that those expenses are going up. We must admit that. We believe the lives we are saving are abundantly worth it. We doubt if the labor leaders and some of the administrators in the social security department who are also critics would wish to go back even to the medicine we knew three years ago, if they themselves or their own family happened to be involved. We all know there are limitations in our Blue Cross-Blue Shield programs. We all know that in many places they are somewhat inadequate for the time and skill demanded and the compensation offered. They have done a job, however, and will again.

The medical profession, evolved from its pioneer days into the completely dedicated, competent profession which is now saving lives lost just yesterday. It did not develop from being adequately paid. The profession did develop from an inner urge of the great mass of our doctors as well as the researchers to do a better job in spite of the frustration and discouragement.

Medicine needs to quit running scared. All of our

members, by taking a new determination, can give even better service than in the past, and can recapture the good will of the public—the respect even of our detractors. That can only be done by fearlessly doing the things which we know must be done. Some of our doctors hesitate in some instances, but hesitation could mean we would all be working for Uncle Sam and that could happen almost over night as we were told by some of the men who are our "outlooks" in the forward ranks.

The Answer

On November 22, 1955, the Michigan Hospital Service petitioned the Michigan Insurance Commissioner for a rate increase of 23 per cent. Protests and criticisms had reached the point where former Governor Williams appointed a Governor's Study Commission which was charged with "determining how more and better medical and hospital services can be assured more people with less criticism, costs decreased, and abuses be controlled or eliminated." There were no answers after prolonged public hearings and tremendous newspaper publicity, but the Commission recommended that a study be set up at the University of Michigan to find out why or how.

Five years later, we have an answer. Two years of inaction and three years of study passed by before the "McNerney Report" was presented to the Governor's Commission on Saturday, July 22. This is the report "financed by grants totalling more than $380,000 from the W. K. Kellogg Foundation of Battle Creek. The three-year University of Michigan study is the most comprehensive analysis yet made of hospital and medical economics in any state."

The report evaluates that:

"Despite the duplication of effort involved in operating two separate plans, both Blue Cross and Blue Shield have done good jobs of keeping their administrative expenses low"; —"The rates of some of the voluntary insurance companies, especially on individual contracts, present a significant limitation on the voluntary health system" because "Blue Cross and Blue Shield pay out approximately 95 per cent of their income in benefits, the figure for private insurance firms ranges from 50 per cent to 90 per cent." "Blue Cross and Blue Shield together write nearly 60 per cent of the total health care coverage in Michigan. Competition from insurance firms, using experience rating, has left the prepayment plans with an increasing share of poor health risks in recent years."

The 1600-page report emphasized the fact that hospital and medical care costs are constantly increasing. That is the report which has gone to the Governor's Commission and which will go to the legislature. It cost $382,000, six years' delay, several sessions with the State Insurance Commissioner with needless publicity and focusing of adverse attention upon the Blue Cross-Blue Shield programs.

The McNerney Report makes many recommendations: that the two Boards be consolidated, that the hospital administrators and the practicing doctors be very largely left off both boards, that insurance laws governing the department be changed providing that the use of experience rating be prohibited as being unfair to the great mass of people, that the Insurance Commissioner exercise jurisdictional authority for all types of health insurance without favoritism or undue severity. It suggests more controls on the part of management and a greater percentage of the doctors participating. It also suggests what Michigan Medical Service board refused to do in the beginning, that we pay the non-participating doctor a lesser amount than the participating doctor. It also suggests that we do not recognize assignment but pay the beneficiary direct, that osteopaths be fully recognized as participants. The report further recommends changing the contracts so that the majority of benefits have as complete coverage as is possible.

The report has extended its investigations and makes further suggestions. Governmental departments that have the responsibility to render medical and especially hospital care should provide full payment of all hospital expenses. (When government now pays only 60 per cent or 90 per cent, the hospitals must collect 100 per cent of costs for Blue Cross and about 117 per cent from private payers.) Underpayment by government should be corrected. "Reimbursement rates to hospitals should be based on uniform cost accounting, established on a state-wide basis, and be at the level of 100 per cent of the audited costs thus established."

The report says:

"Success in improving medical care has cost money, the fact that medical science is producing increasingly useful diagnostic tools and that most of them are housed in the hospital, means higher hospital costs. Pushing back the boundaries of human life is expensive. It is fruitless to question what of this should or should not be done. A more sensible focus should be on how well it is done. Medical advances will continue to bring the supporting population more for its money, although it is extremely unlikely to reduce expenditures."

Future AMA Meetings

AMA's 1962 Annual Meeting will be held in Chicago.

Other locations for meetings are: 1963, Atlantic City; 1964, San Francisco; 1965, New York City.

The 1961 Clinical Meeting will be held in Denver, Colorado, November 26-30 (See page 1201).

AMA Lists Topics for Clinical Meeting

The 15th annual American Medical Association clinical meeting in Denver, November 26-30, will offer the latest findings in a number of areas of medical research to benefit each doctor of medicine in the conduct of daily practice.

Some highlights will include sessions and papers on such important areas of medicine as genes and chromosomes, electronics and computers in medicine, space medicine, medical aspects of American habits, new developments in virology, treatment of radiation injuries, new findings in chemotherapy for cancer, and latest data in the field of antibodies and antigens.

Samuel P. Newman, M.D., of Denver, chairman of the AMA Council on Scientific Assembly, states, "We are confident that the 15th annual clinical meeting will offer one of the most interesting and informative programs ever presented at the winter session." He adds:

"The program is designed to assist the physician in his practice. The latest findings in many areas of medicine will be presented by men who are top specialists in their fields. The meeting will be of great value to the clinician in advancing his knowledge."

* * *

AOA Reacts to AMA Action

The American Osteopathic Association at its annual House of Delegates meeting in Chicago criticized the American Medical Association's efforts at "elimination of the osteopathic profession in the state of California and elsewhere."

The AOA House of Delegates made membership in the Association compulsory for all members of local component societies, voted to step up research on the osteopathic concept, and assessed members $75 for a "war chest" to fight the legal battle currently pending in California.

In addition, dues were raised from $75 to $100 a year.

"We have begged for peaceful coexistence," said True B. Eveleth, executive director of the AOA, "and had hoped that the AMA at their New York meeting would lift their boycott against osteopathy. Instead, they decided on a program which we can only interpret as an attempt to divide and destroy osteopathy."

"Now we will use everything that we have to prevent their going into state associations and dividing us up," he warned.

Delegates were told that organized medicine has made moves in other states to follow California's example.

Mindful of frequent criticisms of the osteopathic concept as unscientific and unproved, the delegates unanimously approved a measure calling for acceleration of "research programs relative to the basic contributions of the osteopathic school of medicine."



Lauds Professional Spirit

"I like to think of the professional spirit as an unchangeable force in medicine. True, its *outward* forms and applications may change with the course of history and alterations in the human environment. But its *essence* is unchangeable, indestructible, like faith in God, belief in freedom, or love of humanity. When the essence of that spirit is diluted or destroyed, either in an individual physician or in a nation, medicine ceases to be a profession in the highest sense of the word.

"*Without* the true professional spirit, the practice of medicine becomes simply an occupation, a way of earning a living. *With* it, the practice of medicine partakes of, and expresses, the best in life, the best in men, the best in human values."

—Leonard W. Larson, M.D.
AMA President, Inaugural Address

Appoint McNerney Blue Cross President

Walter James McNerney, director of the Bureau of Hospital Administration, School of Business Administration, University of Michigan, has been named president of the national Blue Cross Association.

Professor McNerney succeeds James E. Stuart, who became executive vice president of the Association in 1959, president in 1960 and is now chairman of the Association's board of governors.

The new president directed the recently completed three-year study of hospital and medical economics under a grant of $380,000 by the Kellogg Foundation to the University of Michigan. The study concentrated on four major areas: spending and utilization patterns of the population in health care; costs of providing health care; critical issues facing prepayment insurance and government; and the problems of control in the voluntary system.

Name West Virginia Executive

William H. Lively, of Charleston, is the new executive secretary of the West Virginia State Medical Association. He succeeds his father, the late Charles Lively, who served in that capacity from 1942 until his death on June 12. "Bill" has served as executive assistant to his father for six years.

New Look

Leonard W. Larson, M.D., president of American Medical Association, says that his new job will be dealing with issues instead of tissues, malicious rumors instead of malignant tumors and interpretive analyses instead of urinalyses.

More Federal Aid For Health Services

The Senate and House has approved a multi-million dollar expansion of federal aid to community health services. Some of the programs covered by the legislation were of special importance to the aged and the chronically ill.

Key provisions of the bill would:

1. Raise from $30 to $50 million, for five years the annual authorization for matching grants to states and cities for public health services such as home nursing, home health care and a variety of services to nursing homes.

2. Establish a five-year $10 million-a-year program of special grants to non-profit groups for research and development aimed at improved health services given outside the hospital.

3. Raise from $10 million to $20 million the annual authorization for construction of public and non-profit nursing homes.

4. Extend loan provisions for hospital construction under the Hill-Burton Act until its grant program expires in June, 1964.

5. Raise from $1.2 million to $10 million the annual ceiling on grants for hospital research and permit grants for experimental or demonstration hospital units.

6. Extend for three years the matching grant program which provides federal help for construction of health research facilities and authorize $50 million rather than $30 million a year.

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MICHIGAN DEPARTMENT OF HEALTH
ALBERT E. HEUSTIS M.D., State Health Commissioner

State Plan Schedules Six Million for Michigan Hospitals

About six million in federal funds will be distributed this year in Michigan for new construction and expansion of hospitals and other health care facilities, according to the state plan published by the Division of Hospital and Medical Facilities and approved by the Michigan Advisory Hospital Council.

The plan shows that Michigan's greatest needs are more beds for the treatment of mentally ill persons and those requiring lengthy hospitalization and rehabilitation for chronic illness.

Beds for care of the chronically ill in fire-resistive structures with registered nurse supervision constitute only 46 per cent of the number of beds estimated to be needed. Beds in local psychiatric facilities represent 33 per cent of the estimated need. The plan also shows 78 per cent of the estimated number of beds needed for the care of acutely ill patients in acceptable hospital facilities.

In local facilities for the care of the mentally ill, there are only 151 beds currently under construction. During the year, 36 beds in hospital units were made available for this purpose for the first time in Port Huron and Pontiac.

At the state level, a new 300-bed mental facility for western Michigan and treatment units for emotionally disturbed children are badly needed.

There are still a few areas of the state urgently needing construction of adequate general hospital beds. For example, Newberry, Bad Axe, Monroe, Stambaugh, and Ludington have less than 50 per cent of the beds in suitable facilities.

With respect to long-term care facilities, 34 counties still have either no facilities or none in fire-resistive structures where registered nurses are employed to supervise care.

There has been a considerable increase, however, in facilities available for long term care. Two years ago, Michigan had only 27 per cent of the skilled nursing home beds estimated to be needed. Today the figure has risen to 46 per cent to reflect the great upsurge of interest among counties, hospitals and private entrepreneurs in meeting the needs of the chronically ill patient. It also indicates the response to recent legislation making broader health care measures available to the aging.

Since federal construction grants, administered under the Hill-Burton program, started in 1948, $44 million of these funds have been distributed to 141 Michigan projects for new construction or expansion. Grants have been made to 98 individual hospitals and 15 governmental agencies in 78 communities. Nearly half of the construction since 1948 has been with the assistance of federal funds.

The state plan is revised each year and reviewed by the Michigan Advisory Hospital Council, and then sent to the United States Public Health Service for approval. Copies of the plan may be inspected at the Hospital and Medical Facilities Division of the Michigan Department of Health in Lansing.

Live Virus Polio Vaccine Licensed

The Type I oral, live virus polio vaccine developed by Dr. Albert Sabin, has been licensed by the U. S. Public Health Service for marketing in the United States.

However, the PHS, the American Medical Association and others urged that the widest possible use still be made of the Salk killed vaccine. The principal use of the newly licensed oral vaccine this year will be against epidemic threats of Type I polio.

The license for manufacture of the oral vaccine was granted to Pfizer, Ltd., Sandwich, England, and it is being marketed in this country by Chas. Pfizer & Co., Inc., of New York.

Luther L. Terry, M.D., Surgeon General of the PHS, said he expected Type II oral vaccine to be licensed soon but that it would be several months before Type III would be licensed.

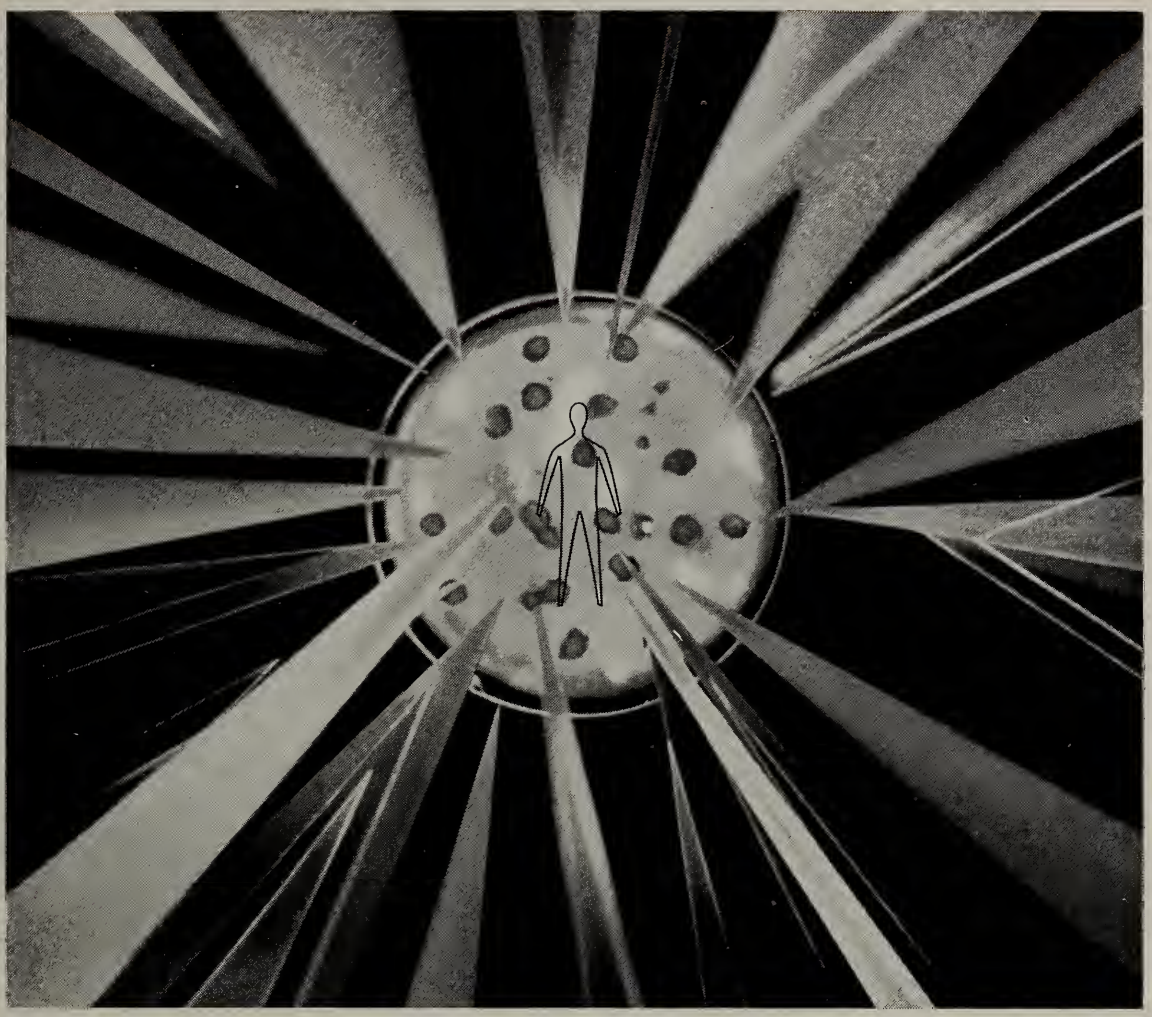
Information on the terms for obtaining vaccine from this epidemic reserve was sent to State and Territorial Health Officers. The requirements include:

At least three cases of Type I polio in the community within a month, of which two have been confirmed to be Type I by laboratory analysis.

Adequate community organization and medical leadership to insure rapid and complete coverage of persons under 50.

Agreement to make the vaccine available without charge to persons under 50.

All local requests must be channeled through State Health Departments.



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Cancer Comment

Leukemias and Lymphomas

The relationship between lymphomas and leukemia is well known but poorly understood. In various types of malignant lymphomas, the terminal picture will be leukemia in 5 to 20 per cent of the cases, depending somewhat on type. The classification of lymphomas varies from article to article and between competent authorities and this difference in nomenclature tends to promote the general confusion. The same story occurs to a lesser degree in the diagnosis of leukemia. The diagnosis of acute leukemia, as far as type is concerned, has always been difficult even with marrow studies, and types of leukemia have been observed to change. Recently, it has been found possible to diagnose lymphogeneous and myelogeneous leukemia more accurately by examining the liver and spleen at autopsy, and employing this method, the clinical diagnosis made by the study of peripheral and marrow smears has been refuted; one recent paper describing nine cases diagnosed originally as monocytic leukemia proved to be lymphogeneous in seven instances, and myelogeneous in the remaining two.

While the study of leukemia in dogs, mice, and other mammals is of interest, the transmission of fowl leukemia appears to be slightly different. The progressive increase of the incidence of leukemia is also alarming, particularly since it has doubled in two decades, not only in the United States, but in other countries. The fact that it occurs at least three times as frequently in males is interesting, and, that it is uncommon in negroes, may point to some factor in host resistance. Fifteen years ago, it was demonstrated that myelokentric acid occurred in the urine in chronic myelogenous leukemia and Hodgkins disease; whereas, lymphokentric by contrast occurred only in lymphosarcomas and chronic lymphogenous leukemia, thus demonstrating a common finding in the two disorders. Clinically, the same difficulty is again encountered in nomenclature, the term "chronic" being employed only in those cases where the disease has been present for a year or longer and acute to those cases which terminate in a few weeks or months. Even in these cases, the study of the peripheral blood may change the terms and it is further complicated by the knowledge that numerous individuals who have had an asymptomatic leukocytosis over a period of years will eventually end as full-blown leukemias.

The classification of lymphomas is not even too clear histologically, since it has been repeatedly demonstrated that a lymph node from one area will show a giant follicular lymphoblastoma, and a node from another site, or even an area in the same node, will show a reticulum-cell sarcoma, and prognostically these are the extremes, since many cases of the former are alive after 15 years and asymptomatic, while the course of the latter is usually brief and fulminating. Statistics are also somewhat vitiated by erroneous diagnoses, cases of cat-scratch fever lymphadenitis and Brucellosis often being classified as Hodgkins disease. A recent review on giant-follicular lymphoblastomas which, parenthetically, is known by at least five different names, points out that this is a distinct type of lymphoma but is not as indolent as formerly thought, since it appears to have a tendency in many cases to develop into a more malignant form. The simplest current classification is to divide the lymphomas into four groups, consisting of follicular lymphoblastoma, reticulum-cell sarcoma, lymphosarcoma and Hodgkins disease and, if one wishes to be more concise, the last can be subdivided into a less progressive granulomatous form. It is of current interest to note, as far as the etiology is concerned, that a rather specific type of malignant lymphoma has a definite geographical incidence in Central Africa among various tribes and particularly in children; in contrast, giant follicular lymphoblastoma is rare in the colored race and almost unknown in small children. Histologically, various competent oncologists have found considerable difference in their statistics, reticulum-cell sarcoma in one large series being only 3 per cent; while in another, 94 per cent were of this type. Since the architecture of the gland, or its lack of architectural pattern is highly important, it is urged that the surgeon remove glands for study in toto and, if possible select more than one node.

ARTHUR A. HUMPHREY, M.D.

Kellogg Grants

With a grant of $115,000 the W. K. Kellogg Foundation of Battle Creek joins other organizations in constructing a new research laboratory for The Wilmer Ophthalmological Institute of The Johns Hopkins University and the Johns Hopkins Hospital. The five-story building will facilitate research into the causes and treatment of blinding ocular diseases.

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HEART BEATS

(This material is provided by the Michigan Heart Association)

"Heart Day"---1962

Among the morning speakers of the Third Annual "Michigan Heart Day" Scientific Sessions, February 10, at the Statler-Hilton, Detroit, will be J. Scott Butterworth, M.D., president-elect of the American Heart Association, and F. Mason Sones, M.D. of the Cleveland Clinic. The afternoon session will feature a panel discussion, "Unexplained Big Heart."

Grants-in-Aid Deadline

Applications for MHA grants-in-aid for the 1962-63 school year may be obtained by request directed to the medical director. The deadline date for applications is December 15, 1961. Investigators presently holding MHA grants will be reminded of the deadline by letter.

New Staff Appointments

Miss Elsie Watt and Mrs. Ruth Kettunen recently joined the staff of the Michigan Heart Association. Miss Watt as consultant on nutrition fills a newly created position, while Mrs. Kettunen, consultant on homemaker rehabilitation, continues the work she has been doing at Michigan State University under a Heart Association grant.

Miss Watt, a graduate of McGill University in Montreal, served her dietetic internship at Montreal General Hospital and later completed a one-year post-graduate course in public health nutrition. She also served four years in the Royal Canadian Air Force as an officer, as county nutritionist in Hawaii, as executive director of a regional dairy council in New York State, and as dietitian of the Albert Schweitzer Hospital in Haiti.

Mrs. Kettunen will lead the Association's program of work simplification for the cardiac homemaker, conducting "Heart of the Home" classes. Bringing this program directly under the operation of MHA is a first step in its expansion. Mrs. Kettunen is a graduate of Washington State College and received her master's degree in home management at Michigan State University, where she specialized in rehabilitation of the disabled homemaker.

Charles Caldwell, formerly Western Regional Director, has opened the new MHA South Central Office in Lansing. His replacement in the Western Office in Grand Rapids is Laurel Kenney, former director of health education for the Kalamazoo County Health Department.

Mr. Kenney was graduated from Seattle Pacific College and received his master's degree in public health at the University of Michigan. A native of Detroit, Mr. Kenney has served the Okanogan County Health Department in Washington state, as well as many years in industry, prior to his work with the health department in Kalamazoo. He is a registered sanitarian with the National Association of Sanitarians and is an active member of several health associations.

Amended "Dangerous Drugs" Act for State Explained

The 1961 Michigan Legislature has amended the "Dangerous Drug" Act, and effective September 9, 1961, amphetamines and methamphetamines and their salts and derivatives are regulated the same as are barbituric acid and its derivatives, chloral hydrate and paraldehyde.

The Dangerous Drug Act, passed initially in 1943, regulates the sale and possession of certain drugs and prescribes penalties for violation of its provisions.

The U. S. Congress is currently considering Senate Bill 1939 for regulating the manufacture, compounding, processing and distribution of habit-forming barbiturate drugs, including amphetamine drugs. This proposed federal legislation defines an amphetamine as "any drug consisting of racemic amphetamine sulfate, dextro amphetamine sulfate, methyl amphetamine hydrochloride, or compounds or mixtures thereof, including all derivatives of phenolethylamine or any of the salts thereof having a stimulating effect on the central nervous system, except preparations intended for use in the nose and unfit for internal use."

In the future, pursuant to the new Michigan statute, the amphetamines and methamphetamines must be recorded by physicians, hospitals, druggists and others in the same manner in which they have dispensed or prescribed the barbiturates.

Brief and to the Point

OFFER BEAUMONT BOOKLET—The Beaumont Memorial Foundation has published a souvenir booklet about the life and work of William Beaumont, M.D. The booklet is entitled "Beaumont and The Mackinac Island Miracle."

It is a most attractive brochure featuring a color reproduction of the famous painting by Dean Cornwell, "Doctor Beaumont At The Bedside of Alexis St. Martin," on the cover. This was printed as information for visitors to the Beaumont Memorial at Mackinac Island and will be on sale there and at the Grand Hotel at fifty cents a copy. Copies may be obtained also from MSMS, Box 152, East Lansing, Michigan.

* * *

BRONSON CLINICAL CONFERENCE—On October 5, Bronson Methodist Hospital, Kalamazoo, will present a Clinical Conference on Problems in Gastroenterology.

The program will be in the form of a symposium and will feature an outstanding group of panelists. Members of the panel will include Philip J. Hodes, M.D., of Jefferson Medical College, Malcolm B. Dockerty, M.D., of the Mayo Clinic, Edwin H. Ellison, M.D., of Marquette University and J. Edward Nerk, M.D., of Wayne University.

Edward B. D. Neuhauser, radiologist in chief at the Children's Hospital in Boston, will be the guest lecturer at the evening program and will address the group on "Some Problems in Gastroenterology," following a dinner at the Harris Hotel.

* * *

SERVES BEAVER ISLAND—Sydney S. Schochet, M.D., of Sault Ste. Marie, began duties September 1 as the Beaver Island physician, succeeding Frank E. Luton, M.D., who retired after 60 years of medical practice. Doctor Schochet has been pathologist at the War Memorial Hospital at Sault Ste. Marie, and has had a career of pathology, private practice and teaching.

* * *

STATE M.D. HONORED—DeWitt T. Burton, M.D., Detroit, has been named by President Kennedy to the National Advisory Committee on the Selection of Physicians, Dentists and Allied Scientists. Doctor Burton serves also on the Board of Governors of Wayne State University.

* * *

NAMED CHAIRMAN—E. Eric Muirhead, M.D., of Detroit is chairman of the Scientific Committee of the Joint Blood Council, chosen at its recent annual meeting in New York. Gunnar Gundersen, M.D., LaCrosse, Wisconsin, is the Council president.

* * *

STRESSES AUTO SAFETY—An article "How Safe Is Your Car?" written by John R. Rodger, M.D., Bellaire, was circulated recently by the AMA Council on Rural Health to farm magazines. Doctor Rodger, chairman of the MSMS Study Committee on Prevention of Highway Accidents, is a member of that AMA Council. One of the points made by Doctor Rodger is the prediction that 5,000 lives could be saved annually "if all cars were equipped with safety belts and were used."



OCCUPATIONAL HEALTH CONGRESS—The Annual Session of the Colorado State Medical Society will be combined this year with the Congress on Occupational Health, sponsored by the American Medical Association. The meeting will be held at the Brown Palace and Shirley Savoy Hotels in Denver on October 1-4. Leonard E. Himler, M.D., Ann Arbor is one of the speakers.

* * *

POSTGRADUATE COURSES—The American College of Physicians has announced its "Schedule of Post Graduate Courses" for the fall-winter, 1961-62: Columbus, Ohio State University, September 18-23; Durham, N. C., Duke University, October 9-13; Mayo Clinic, Rochester, Minn., November 6-10; New York City, New York University Medical Center, December 4-8; New Orleans, Ochsner Foundation Hospital, January 15-18, 1962; Ann Arbor, University of Michigan Medical Center, January 29-February 2, 1962; St. Louis, Mo., Washington University School of Medicine, February 12-16, 1962; Houston, Texas, Baylor University College of Medicine, February 19-23, 1962.

* * *

KELLOGG ASSISTS—Rutgers University is planning to establish a two-year medical school curriculum. The first class of 50 students is scheduled to enroll in the fall of 1963. A $1,073,200 grant from the W. K. Kellogg Foundation will aid the university in establishing the program.

BOOKLET OFFERED—"Your Cholesterol Depressant Diet Cook Book" has been reprinted and is available upon request from Wesson, 210 Barrone St., New Orleans, La.

* * *

ESSAY CONTEST—The Trustees of America's oldest medical essay contest, the Caleb Fiske Prize of the Rhode Island Medical Society, announce two subjects for this year's dissertation, open to all doctors of medicine with cash prizes of $500. The subjects chosen are: "RECENT ADVANCES IN THE TREATMENT OF MALIGNANT DISEASE," and "CURRENT STATUS OF CARDIAC SURGERY." For full information, write to the Secretary, Fiske Fund, 106 Francis Street, Providence 3, Rhode Island.

* * *

STUDENT AID—The Association of American Medical Colleges has published a 28-page booklet listing sources of information on financial aid to medical students. The booklet is free from the Association, 2530 Ridge Ave., Evanston, Ill.

* * *

MEDICAL MEETINGS, U.S.A.

American Academy of Pediatrics, October 2-5, Palmer House, Chicago. E. H. Christopherson, M.D., 1801 Hinman Ave., Evanston, Ill., Executive Director.

American College of Surgeons, October 2-6, Conrad Hilton Hotel, Chicago. William E. Adams, M.D., 40 E. Erie St., Chicago 11, Secretary.



American Association of Poison Control Centers, October 3, Palmer House, Chicago. Harry C. Shirkey, M.D., Children's Hospital, 712 South 30th St., Birmingham, Ala., Director.

American Academy of Ophthalmology and Otolaryngology, October 8-13, Palmer House, Chicago. William L. Benedict, M.D., 15 Second St., S.W., Rochester, Minn., Executive Secretary.

Indiana State Medical Association, October 24-26, Murat Temple, Indianapolis. Mr. James A. Waggener, Indiana State Medical Association, 1021 Hume Mansur Building, Indianapolis 4, Executive Secretary.

American Association of Blood Banks, October 25-28, Drake Hotel, Chicago. Frank E. Trobaugh, Jr., M.D., Presbyterian-St.Luke's Hospital, 1753 W. Congress, Chicago 12, Secretary.

Gerontological Society, November 10-12, Pittsburgh. Robert W. Kleemeier, M.D., Washington University, St. Louis 30, Secretary.

American Association of Public Health Physicians, November 13-17, Detroit. J. M. Bistowish, M.D., P.O. Box 1568, Tallahassee, Fla., Secretary-Treasurer.

American Public Health Association, November 13-17, Cobo Hall, Detroit. Berwyn F. Mattison, M.D., 1790 Broadway, New York 19, Executive Director.

American Psychiatric Association, November 16-18, Hotel Schroeder, Milwaukee. Miss Joan D. McGucken, 756 N. Milwaukee St., Milwaukee 2, Administrative Assistant.

Radiological Society of North America, November 26-December 1, Palmer House, Chicago. Mr. Maurice D. Frazer, 3145 O Street, Lincoln, Neb., Secretary.

American Medical Association, Clinical Meeting, November 27-30, Denver. F. J. L. Blasingame, M.D., 535 N. Dearborn St., Chicago 10, Executive Vice-President.

American Academy of Dermatology and Syphilology, December 2-7, Palmer House, Chicago. Robert R. Kierland, M.D., Mayo Clinic, Rochester, Minn., Secretary-Treasurer.

American Academy of Orthopaedic Surgeons, January 27-February 1, 1962, Palmer House, Chicago. Mr. John K. Hart, 29 E. Madison St., Room 910, Chicago 2, Executive Secretary.

* * *

MORE GRANTS—Nearly 300 agencies across the nation received grants totaling $592,485 from the Smith Kline & French Foundation during 1960. More than $4 million in grants has been distributed by the Foundation since its beginning in 1952.

During 1960, grants for education totaled $363,765, grants totaling $94,333 were made to institutions and organizations active in the field of mental health, grants totaling $122,787 were made to public charities and community improvement, and grants totaling $11,600 were made for specific research projects.

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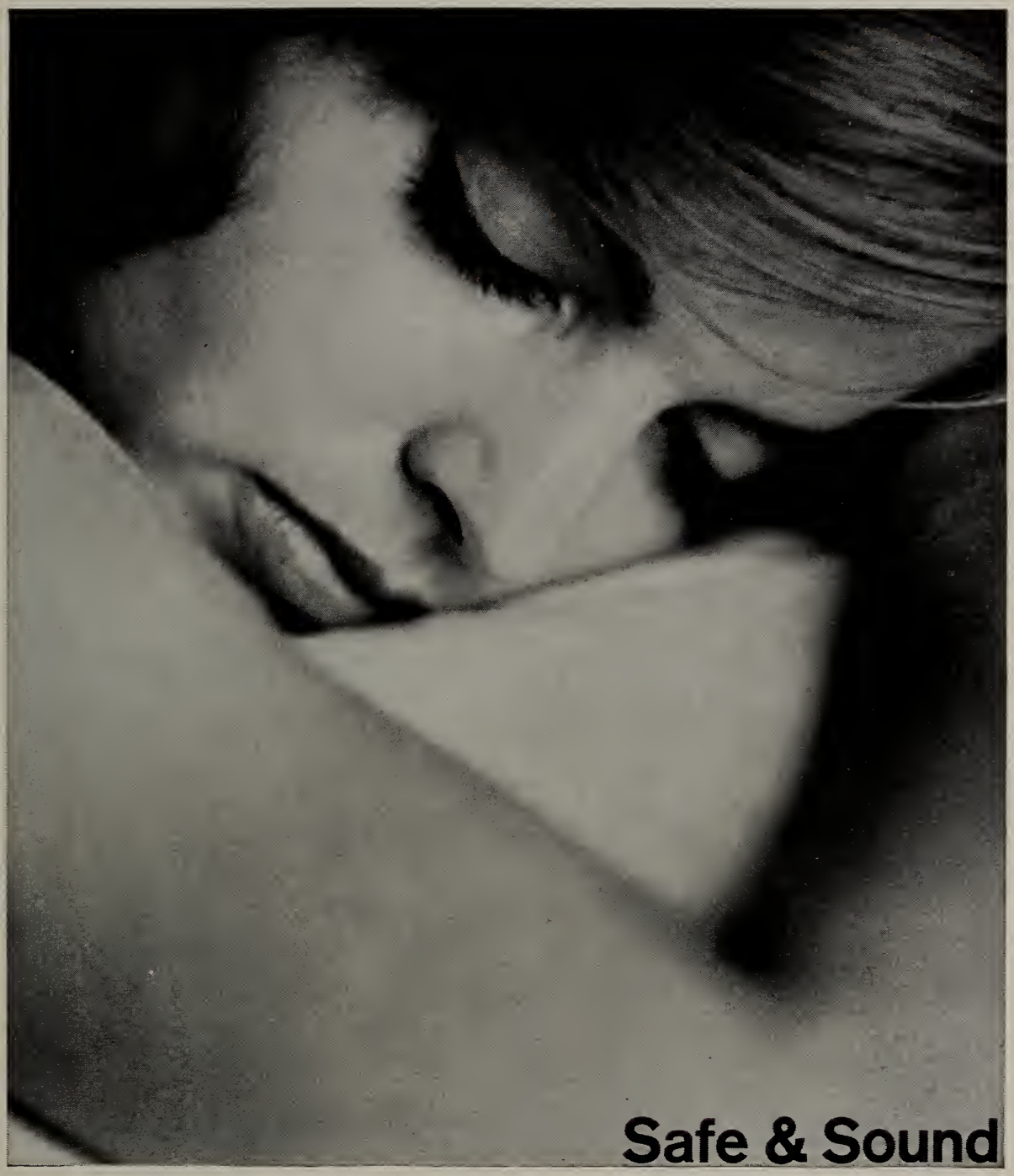
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IN MEMORIAM

ERNEST W. BLANCHARD, M.D., fifty-five, Deckerville physician for 26 years, died unexpectedly June 29, 1961.

Doctor Blanchard was graduated from the University of Michigan Medical School in 1932, served a two-year internship in Detroit at Grace Hospital, then set up practice in Traverse City for a short time before beginning his practice in Deckerville, in 1935.

Deckerville's first hospital was built by Doctor Blanchard in 1952. He served as Deckerville village president for several years and served on the board of education for 18 years, most of that time as president, which title he held at his death.

He was a past president of the Sanilac County Medical Society, and most active in the activities of the Michigan State Medical Society, serving as president of the County Secretaries organization in 1954.

JOHN J. BURKE, M.D., seventy-five, Lake Linden physician, died June 29, 1961.

Doctor Burke was graduated from Northwestern Medical School in 1910, serving his internship at Sacramento Hospital in Sacramento, California. After practicing in Algomah, Wisconsin, for a few years, he served as a civilian doctor at Fort Sherman in Chillicothe, Ohio and then practiced at Rice Lake, Wisconsin. He moved to the Torch Lake area in 1927 and served on the staff of Calumet and Hecla Hospital until its closing. He has been in private practice in the Torch Lake area since that time.

Doctor Burke was a Life Member of the Michigan State Medical Society.

DUNCAN A. CAMPBELL, M.D., eighty-six, Detroit eye, ear, nose and throat specialist for 60 years, died July 2, 1961.

A graduate of Wayne State University College of Medicine, Doctor Campbell served his internship and residency at Harper Hospital.

Memberships included the American Academy of Ophthalmology and Otolaryngology, Detroit Ophthalmological Society, Detroit Society of Otolaryngology and the Detroit Academy of Medicine. He was a Life Member of the Michigan State Medical Society and Past-President of the Harper Hospital Golf Association.

FREDERICK P. CURRIER, M.D., seventy-three, of Grand Rapids, died July 5, 1961.

Doctor Currier was graduated from the University of Michigan Medical School in 1916, interning at Grand Rapids Blodgett Hospital. He was the first neurologist and psychiatrist to practice in Western Michigan.

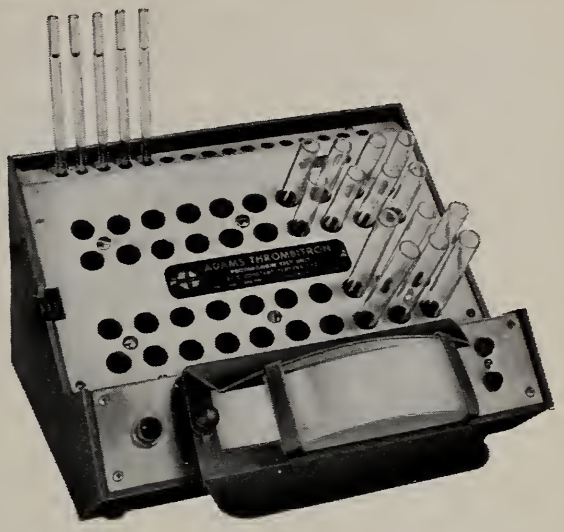
He was a retired member of the Michigan State Medical Society. Other memberships included the Rotary Club, Kent County Club and the Peninsular Club. Professional associations of which he was a member are the American Psychiatric Association, American Academy of Neurology, and Central Neuro-Psychiatric Association.

(Continued on Page 1224)

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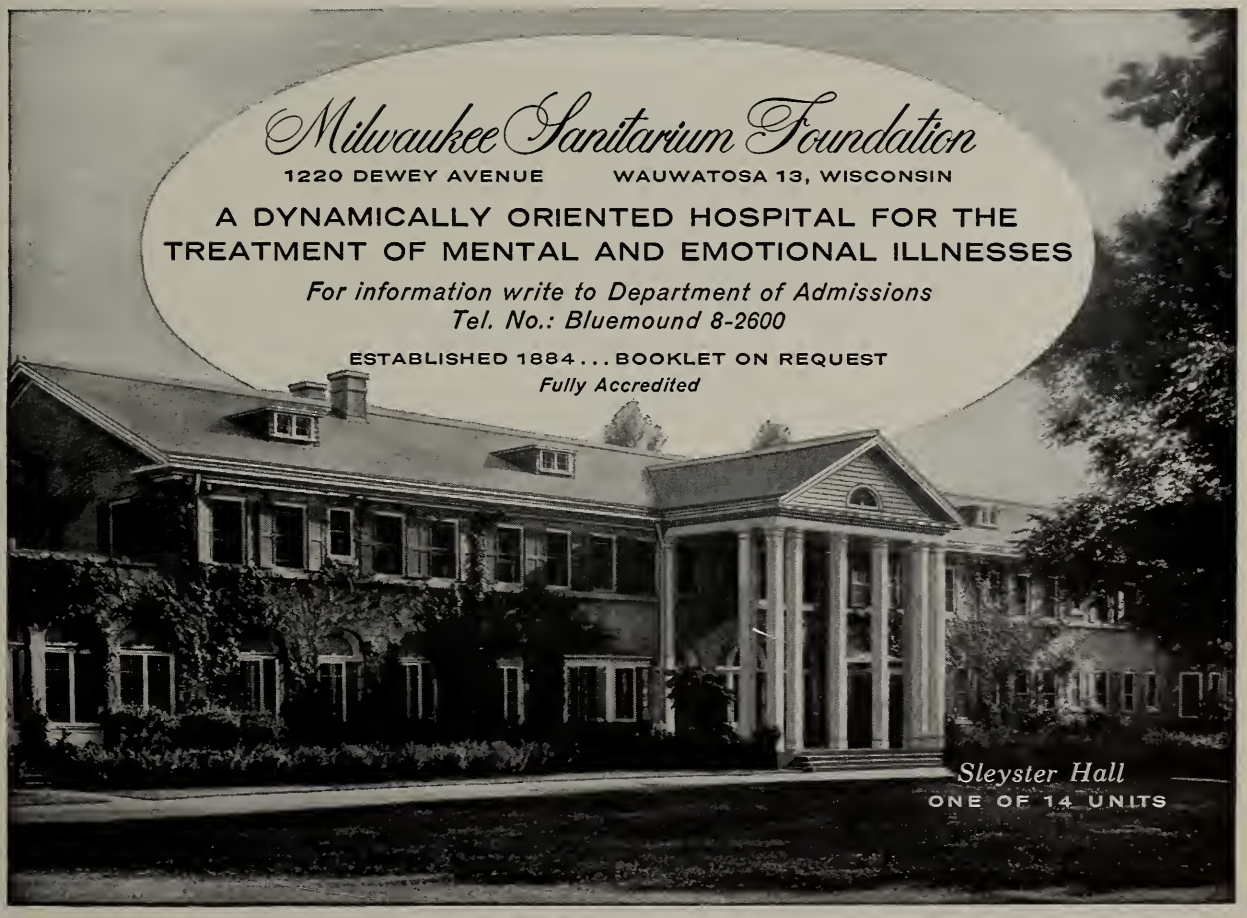
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(Continued from Page 1222)

JOSEPH G. ISRAEL, M.D., sixty-five, Detroit physician, died July 7.

A native of Russia, Doctor Israel attended New York University and Tufts Medical College. He was an instructor at the Detroit College of Medicine and a member of the International College of Surgeons and the American College of Surgeons.

Dr. Israel, a surgical consultant for Grace Hospital, had been a member of the Selective Service Board in Wayne County for 31 years. He was active in the committee structure of the Wayne County Medical Society.

DONALD McDIARMID, M.D., thirty-four, Muskegon physician, died in an accident July 8, 1961.

Doctor McDiarmid graduated from Wayne State University College of Medicine. He served in the Army from 1945 to 1947. He was an associate member of the Michigan State Medical Society.

EDWIN E. MILLER, M.D., seventy-seven, retired Flint physician, died July 1, 1961.

Doctor Miller had practiced in Flint for 40 years. He was a Life Member of the Michigan State Medical Society and the American Medical Association.

HAROLD F. OSTERHAGEN, M.D., fifty, Traverse City anesthetist, died July 6, 1961, in a hunting accident.

Doctor Osterhagen was graduated from the University of Iowa College of Medicine in 1935. He came to Michigan in 1946.

He was a past president of the Michigan State Society of Anesthesiologists and the Grand Traverse-Leelanau-Benzie County Medical Society, and former president of staff of Munson Hospital. He was a Fellow of the American College of Anesthesiologists and a member of the American Society of Anesthesiologists.

LEAL K. SLOTE, M.D., eighty-four, physician in Constantine for 51 years until his retirement in 1951, died July 6, 1961.

Doctor Slote was graduated from the University of Michigan Medical School in 1900, following which he began his practice in Constantine.

He was a past president of the St. Joseph County Medical Society and a Life Member of the Michigan State Medical Society. He served as a member of the Constantine School Board for 25 years.

EDWARD H. STAHLY, M.D., sixty-four, medical director of Saginaw County Hospital's Tuberculosis Division, died July 7, 1961.

Doctor Stahly was graduated from the University of Nebraska College of Medicine and in 1929 he received a degree in tropical medicine and hygiene from the London School of Tropical Medicine and Hygiene in London, England.

From 1929 until 1934 he was a medical missionary in India. From 1937 to 1944 he served as a resident physician at Maybury Sanatorium in Northville, Michigan. In 1944 he became medical superintendent of Saginaw County Hospital and since then had served a key role in its executive activities.

He was nationally recognized for his work in the field of tuberculosis treatment and care. Memberships included the American Trudeau Society, National Tuberculosis Association, and Michigan Tuberculosis Association. He was on the staff of the Saginaw VA Hospital, St. Luke's Hospital and Mt. Pleasant's Central Michigan Community Hospital. He had served as secretary of the Saginaw County Tuberculosis Rehabilitation Service.

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JCC Opposes King Bill

A resolution opposing the King-Anderson bill to provide health care for the aged through social security was adopted overwhelmingly by the U. S. Junior Chamber of Commerce at its annual meeting in Atlanta, Georgia.

The resolution said the Jaycees believe the King-Anderson bill "would destroy our voluntary health program in the U. S." and would be another step toward socialism.

Copies of the resolution will be sent to President Kennedy, Vice-President Lyndon Johnson, HEW Secretary Abraham Ribicoff and to every member of Congress.

The Jaycees instructed their national officers to request time to testify against the bill at hearings of the House Ways and Means Committee this month.

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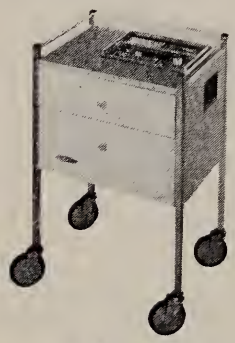
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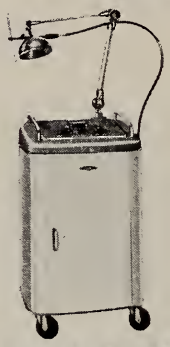
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COMMUNICATIONS

Wilfrid Haughey, M.D., Editor
Journal of Michigan State Medical Society
Battle Creek, Michigan

Dear Dr. Haughey:

I should like to refer to your Editorial "Kerr-Mills Act versus the King-Anderson Bill," which appeared in the J.M.S.M.S., June 1961. In referring to the King-Anderson Bill you state, "No medical service or surgical service is included." It has evidently not come to your attention that the King-Anderson Bill provides for Anesthesiology Service.

At the present time individuals within our society are making every effort to acquaint our entire membership with this fact. As physicians in the private practice of medicine, we violently object to being placed in the category of hospital employees.

I have received a number of communications from anesthesiologists concerning the disparity of the information that they have received from us and that provided in your Editorial. If it is at all possible I should like to respectfully request that this error be corrected.

Sincerely,
ELI M. BROWN, M.D.
President, Michigan Society of Anesthesiologists, Inc.

July 24, 1961

EDITOR'S NOTE: The Bill reads, "Excluding, however,—(4). Medical or surgical services provided by a physician, resident, or intern, except in the field of pathology, radiology, physiatry, or anesthesiology, and except services rendered in a hospital by an intern or a resident-in-training under a teaching program approved by a recognized body approved for the purpose by the Secretary."

Otto K. Engelke, M.D.
President-Elect
Michigan State Medical Society

Dear Dr. Engelke:

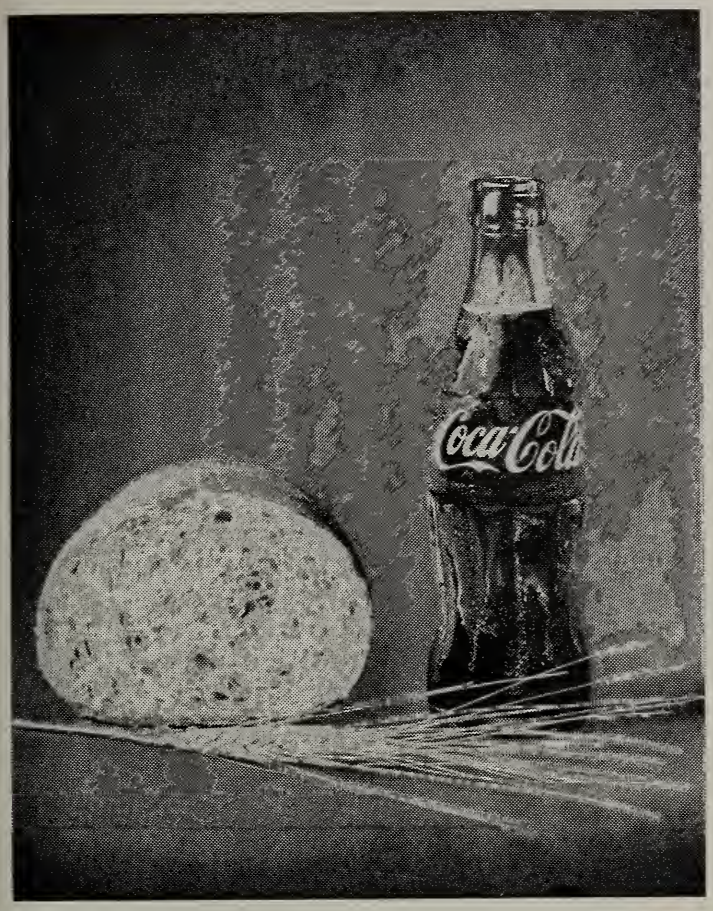
This is just a note to congratulate you on the excellent job which you did in your appearance before the House Ways and Means Committee in testifying on H.R. 4222, 87th Congress. Your testimony was well presented and was definitely well received by the committee.

All of us who had anything to do with the hearings were very proud of the appearances of all of the medical witnesses. I am confident that the cumulative effect of the statements presented on behalf of the national, state, and county medical societies will demonstrate without question the lack of need for legislation such as H.R. 4222. We are indebted to you for the obvious time and effort which was put into your presentation. You and Mike Riley have every right to be pleased with this job which was extremely well done.

Sincerely yours,
C. JOSEPH STETLER, *Director*
Legal and Socio-Economic Division
American Medical Association

August 16, 1961

(Continued on Page 1228)



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(Continued from Page 1226)

Dear Doctor:

The 10th Annual Conference of the U. S. Civil Defense Council will be held the week of October 16-20 in Los Angeles, Hotel Ambassador. Doctors with a civil defense responsibility or interest are especially urged to attend.

The program is extremely worthwhile. Emphasis is on thermonuclear effects, radiation, survival, shelters, and reactions in a disaster. Medical workshops on disaster and the physician's role in the community civil defense program are timely and important topics to our profession.

Sincerely,
ROBERT J. SAMP, M.D.
Area 4 Medical Representative
USCDC Health Services Committee

610 Odell Street
Madison, Wisconsin
July 17, 1961

Work of AMA Council On Drugs Spotlighted

Question: The AMA considers its drive for higher standards of training and its fight against quacks as its two major contributions—what does AMA rate as its third most important accomplishment?

Answer: AMA's long and constructive influence in behalf of greater scientific accuracy and more dependable therapeutic agents.

* * *

Exactly one year after AMA was founded, John B. Johnson, M.D., of Missouri, introduced in 1848 a resolution pointing out that numerous and important evils result from the universal practice of allowing persons, almost wholly ignorant, to engage in apothecaries. He urged that schools of pharmacy be established and that rules be adopted that no physician patronize a druggist or an apothecary who deals in "patent" or secret medicines.

Through the years, the AMA has helped to bring about new concepts of pharmaceutical integrity.

In 1905, the AMA established the Council on Pharmacy and Chemistry (now known as the Council on Drugs) to police the widespread drug advertising which promoted false claims and secrecy of formulae.

The Doctor's Library

Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

SURGICAL DISEASES OF THE CHEST. Edited by Brian Blades, M.D., Professor of Surgery, The George Washington University School of Medicine, Washington, D. C.; Chief Surgeon, The George Washington University Hospital, Washington, D. C. 267 illustrations. St. Louis: C. V. Mosby Company, 1961. Price, $22.00.

This is a rather comprehensive summary of the surgical diseases of the chest presented by a host of authors writing in their particular fields. It is designed to be useful not only to chest physicians and surgeons alike, but to general practioners and students of medicine who are interested in broadening their knowledge in this field. The subject material is stripped of minutiae and contains the hard information required to form conclusive judgments in daily practice.

There is extensive development of tuberculosis and bronchogenic carcinoma. The surgical aspects of congenital and acquired heart disease are discussed in several excellent chapters. In addition to this, extended commentary on the less commonly encountered entities is present. All material is written in a readable concise fashion. An excellent preliminary chapter by Dr. Beattie elucidating pertinent basic physiology of the cardiopulmonary system lays the foundation for the following chapters.

This book will be a well-placed item on the bookshelves of those who desire to keep current with the recent concepts of chest disease and on the latest possibilities in the surgical management of these problems.

J.G.G.

MANAGEMENT OF HYPERTENSIVE DISEASES. By Joseph C. Edwards, A.B., M.D., F.A.C.P., F.A.C.C., Assistant Professor of Clinical Medicine, Cardiovascular Consultant to Division of Gerontology, and Consultant in the Hypertension and the Cardiac Clinics, Washington University School of Medicine and Barnes Hospital, St. Louis, Mo.; Cardiologist and Director of Hypertension Clinic, St. Luke's Hospital, St. Louis, Mo.; Active Staff Physician, Deaconess Hospital, and Member of Consultant Staff, Missouri Baptist Hospital and St. Joseph Hospital, St. Louis, Mo.; Consultant, Council on Drugs, American Medical Association; Medical Consultant, Fifth Army of the United States, Office of the Surgeon, Chicago, Ill. With Foreword by Paul Dudley White, M.D. Illustrated. St. Louis: C. V. Mosby Company, 1960. Price, $15.00.

This is an up-to-date treatise which stresses the practical management of hypertensive disease. As the author states in the preface, it is written for the busy practitioner to provide the latest information in the management of the patient.

The book deals not only with management, but contains chapters on the hypertensive drugs, their pharmacology and therapy, and also a chapter on the etiology of hypertension particularly essential hypertension, which is most informative. Diagnostic aspects are also included, as well as a discussion of the electrocardiogram in hypertension.

A special chapter dealing with hypertension and pregnancy is written by various authors.

An extensive bibliography of reference is included.

This would be a very important addition to the library of anyone who treats hypertensive patients. The reviewer considers it the best book on the subject that he has thus far examined.

R.W.B.

INTRA-ABDOMINAL CRISES. By Kenneth D. Keele, M.D., F.R.C.P., Consultant Physician, Ashford Hospital, Middlesex (Staines Group) and Norman M. Matheson, F.R.C.P., M.R.C.P., F.A.C.S., Consultant Surgeon, Ashford Hospital, Middlesex (Staines Group). London: Washington Butterworths, 1961. Price, $10.00.

These British authors present this interesting monograph of close to 400 pages on the subject of the patient suffering from abdominal pain and vomiting. The book attempts an analysis of the diagnostic aspects of the problem, and outlines early methods of management and diagnosis.

The main theme of the book is the role of the diagnostician rather than the surgical aspect of these problems and emphasizes the role of the internist in their investigation.

Though the management is typically British, under the system of National Health Insurance, employing such available facilities in the handling of these emergency situations, the text has wide application to our own problems when faced with these situations. Some of the antibiotic procedures involved might not be entirely acceptable here.

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The book is well written and well illustrated, is brief in its discussion, and seems well organized. One objection, from the reviewer's point of view, is the cross-indexing, referring to chapters rather than to specific pages, which would be of definite advantage.

The book is very interesting, particularly some of the illustrations, and well worth adding to one's library.

R.W.B.

PHYSICIAN MOBILITY IN WAYNE COUNTY. By Celia Berlin Kliger. Privately printed, 1961.

This book, privately printed by the author, is a thesis written in partial fulfillment of the requirements for the degree of Master of Public Health Administration, Wayne University, Detroit, June, 1961. A copy will remain in the Medical School library as the only reference work of its kind.

The subject matter deals with the movement of physicians, why they move, their schools, specialties represented; locale of offices in relation to homes and hospitals, economic status and population changes. A study was made of the military physician, racial and nationality groups, the woman physician and the changes in office building occupancy in relation to age and type of practice.

Observations are drawn from a systematic, laborious and meticulous examination of the roster of the Wayne County Medical Society for the years 1948 and 1959, the same names being checked later in the AMA Directory for 1950 and 1958. A 10 per cent sample was used as the base, and to this was added further sampling to secure information about the new physician. All the information plus current findings in the local telephone directory were plotted on the map of the Detroit postal areas.

Some interesting findings emerge:

Most doctors in the base sample were fifty-one to fifty-five years old, whereas new physicians were twenty-five to thirty-five.

Doctors aged forty-one to sixty are leaving downtown office buildings.

Of the physicians checked, 67 per cent came from the Michigan schools; 28 per cent were from out-state; 5 per cent were foreign graduates. But only 30 per cent of new physicians came from the local schools; 46 per cent were from out-state; 24 per cent were foreign graduates.

Most of the migration was from downtown and the New Center area. More full-time specialists left than did part-time specialists. The southeast and southwest neighborhood areas lost both specialists and general practitioners. Migration is to the northwest area and to the northeast suburbs.

Physician population changes follow general population changes, and this in general is determined by economic status.

Significantly, 90 per cent of the original sample were in private practice; only 56 per cent of the new physicians are in private practice.

When doctors move, proximity of office and hospital is more important than proximity of office and home.

Wayne County lost 20.5 per cent of general practitioners and gained 20.5 per cent specialists.

The book represents an original work, encouraged and

THE PHYSICIAN AND THE CANCER PATIENT

The American Cancer Society is concerned with the *total* cancer problem. A crucial part of this problem relates to the cancer patient and his family. To help the medical profession explore ways and means of meeting the patient's special needs, the scientific session of the Society's next Annual Meeting at the Hotel Biltmore in New York City, October 23-24, 1961, will be devoted to "The Physician and the Total Care of the Cancer Patient." Various specialists will examine the psychological and physical problems facing the cancer patient and his family. Consideration will be given to such topics as decisions in the early care of the cancer patient, counselling the cancer patient, what the patient should be told, care of the advanced cancer patient, society's role in service to the cancer patient.

Through such meetings, the American Cancer Society serves the medical profession by providing a forum for an exchange of information and experience concerning the cancer patient.

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guided by the writer's professor-advisor, Dr. Robert J. Mowitz. It is replete with forty tables, fourteen illustrations and 135 footnotes. It is sometimes bewildering in its complexity which speaks for the orderliness of the analytical process followed by the author.

Whether a 10 per cent sampling of the type employed would appear valid to the trained statistician (some of the tables show as little change as one physician representing one specialty among eighteen studied), it remains that the work was painstaking, difficult and original. It has shown what was often suspected about the movements of physicians in relation to age, specialty and economic status.

The author is accomplished in many ways. She is a graduate nurse, Highland Park General Hospital; Bachelor of Science in Education, Mercy College, 1960; Master of Health Administration, 1961. She has a long list of acknowledgments and recognitions and is a member of numerous professional societies. She is the wife of Dr. David Kliger, a well-known Detroit physician.

L.J.B.

LAENNEC: HIS LIFE AND TIMES. By Roger Kervran, M.D. Translated from the French by D. C. Abrahams-Curiel. New York, Oxford, London, Paris: Permagon Press, 1960. Price, $3.50.

This is a very readable, interesting, biography of René Laennec, the inventor of the stethoscope, and early phthisiologist. Dr. Kervran is a native of Brittany, near the area where Laennec lived. He presents more than a biography of his scientific work and medical contribution, and also includes anecdotes of his everyday life, tying it into the life and times in his native Brittany.

It is an extremely readable book, of slightly more than 200 pages, printed in good type. The reviewer, who is not particularly interested in biography, found the book most readable.

R.W.B.

HEREDITY IN OPHTHALMOLOGY. By Jules Francois, Professor of Ophthalmology at the University of Ghent, Belgium, member of the Academy of Medicine. Translated from the French edition, entitled L'Hérédité en Ophthalmogie. 629 illustrations including 6 in color. St. Louis: C. V. Mosby Company, 1961. Price, $23.00

The English translation of the author's original French version is a most unusual and elaborately detailed exposition of ophthalmological conditions as they are related to specific diseases or conditions or hereditary conditions. It discusses the Mendelian theory and the various inheritance philosophies. It has more than 600 illustrations, diagrams and pictures, mostly showing the inheritance characteristics or ideas or implications. Mutations, heredity and environment, genetics are all discussed. There are also sections devoted to hereditary diseases of the eye, cataract, glaucoma, general diseases with ophthalmic manifestations, diseases of the blood and the endocrine system. They are all discussed. There are literally hundreds, in fact, 25 pages of author references. Harold F. Falls, M.D., of Ann Arbor, is referred to 36 times. It is a most interesting and intriguing book.

BIOLOGY OF PYELONEPHRITIS. Henry Ford Hospital Symposium. Editors: Edward L. Quinn, M.D., F.A.C.P., Physician in Charge, Division of Infectious Diseases, Department of Medicine, Henry Ford Hospital and Edward H. Kass, M.D., Ph.D., M.A. (hon.), F.A.C.P., Associate Professor of Bacteriology and Immunology, Harvard Medical School; Associate Director, Mallory Institute of Pathology, and Associate Physician, Thorndike Memorial Laboratory, Boston City Hospital. Boston: Little, Brown and Company, 1960. Price, $18.00.

This is one of the few books in the field which synthesizes current knowledge of pyelonephritis. It contains excellent reviews on pathogenesis, experimental approach, the physiobiochemistry, and immunology of pyelonephritis.

This serves as an excellent reference to current experimental thought on pyelonephritis.

J.A.G.

AT YOUR BEST FOR BIRTH (AND AFTERWARDS). By Eileen Montgomery, M.C.S.P. With a Foreword by H. L. Shepherd, Ch.M., F.R.C.O.G., Consultant Obstetrician and Gynaecologist, United Bristol Hospitals; Lecturer in Obstetrics, University of Bristol, Bristol: John Wright & Sons Ltd., 1959. Price, $1.75.

This concise handbook is of value to the pregnant woman and to those teaching expectant parents. There are numerous diagrams with explanations of exercises, posture and muscle training which are of great value during pregnancy and the period following.

The author has bridged the gap between the expectant parent and her doctor. Emotional reactions and fear of the unknown are excellently treated and in a language a layman can understand.

J.R.P.

Say you saw it in the Journal of the Michigan State Medical Society

BOOKS RECEIVED

SALMONELLA; SALMONELLA INFECTIONS. Bibliography of Literature, 1955—April, 1960. National Library of Medicine Reference Division. Compiled by Dorothy Bocker, M.D., Medical Officer. U. S. Department of Health, Education and Welfare. Washington, D. C.: Public Health Service, 1960.

PHYSIOLOGY OF THE EYE. Clinical Application. By Francis Heed Adler, M.A., M.D., F.A.C.S., William F. Norris, and George E. de Schweinitz, Professor of Ophthalmology, University of Pennsylvania School of Medicine, and Consulting Surgeon, Wills Hospital, Philadelphia. 372 illustrations; 2 in color. Third edition. St. Louis: The C. V. Mosby Company, 1959. Price, $16.00.

THE FAMILY HANDBOOK OF HOME NURSING AND MEDICAL CARE. By I. J. Rossman, M.D., Ph.D., Chief of Professional Services, Home Care Department, Montefiore Hospital, New York, and Doris R. Schwartz, R.N., Assistant Professor in Outpatient Nursing, The Cornell University-New York Hospital School of Nursing, New York. A Dolphin Reference Book. Garden City, New York: Doubleday & Company, Inc., 1961. Price, $1.45.

THE MODERN TREATMENT OF ASTHMA. With Special Reference to Cold Therapy. By L. Banszky, M.D. (Berlin), L.M.S.S.A. (Lond.). Second edition. Bristol, England: John Wright & Sons, Ltd., 1959. Price, $5.00.

ELECTRICAL IMPEDANCE PLETHYSMOGRAPHY. The Electrical Resistive Measure of the Blood Pulse Volume, Peripheral and Central Blood Flow. By Jan Nyboer, D.Sc., M.D., Chief, Division Cardiovascular Physiology Research, Electrocardiographer and Associate Physician, Department of Medicine, Harper Hospital, Detroit, Michigan; Professor, Department of Physiology and Pharmacology, Wayne State University Medical School, Detroit, Michigan. Foreword by Franklin D. Johnston, B.S. (Eng'g), M.D. Springfield, Illinois: Charles C Thomas, 1961. Price, $7.50.

SYMPOSIUM ON GLAUCOMA. Editor, William B. Clark, M.D., F.A.C.S., Diplomate, American Board of Ophthalmology; Professor of Clinical Ophthalmology, Tulane University School of Medicine, New Orleans, La.; Chairman, Advisory Council on Ophthalmology, American College of Surgeons; Member, American Ophthalmological Society; Member, American Academy of Ophthalmology and Otolaryngology. Associate Editor, Joe M. Carmichael, M.S.J. 99 figures; 2 in color. Transactions of New Orleans Academy of Ophthalmology, 1957. St. Louis: The C. V. Mosby Company, 1959. Price, $13.50.

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Volume 60 Number 10
October, 1961

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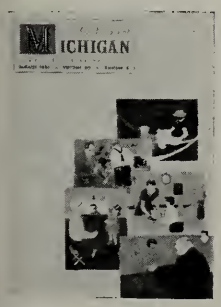
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THE COVER

This month's cover portrays the various activities in which the senior citizen may occupy his time to advantage both in entertainment of self and in service to his community, a combination of work and play that leads to healthful old age.

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President's Page

CONTINUED LEADERSHIP NEEDED



President
Michigan State Medical Society

Your Michigan State Medical Society recently presented a statement about medical care of the aged to the Ways and Means Committee of the House of Representatives of the Congress of the United States. Our immediate objective was the defeat of the Social Security approach, i.e., H.R. 4222. We said, "Such an approach is compulsory national health insurance, and that compulsory national health insurance is socialized or nationalized medicine."

We pointed with pride to the Michigan medical profession's history of "first" in providing the means of securing medical care for those who needed it. Michigan State Medical Society Pioneering in developing Blue Shield was described.

Our state's pre-eminence in its program for providing medical aid to the aged received special attention. We reported that "The Michigan M.A.A. plan was heartily endorsed by the Michigan State Medical Society as a plan that would meet the medical needs of Michigan's elderly citizens who require financial help." And it is.

Our positive approach to medical care of the aged was cited as good reason why the Social Security plans were unnecessary. If we are called upon to appear before Congress next year we hope to be able to report more progress.

Our continued leadership in this whole area of medical care is expected by everyone. We must be certain that current M.A.A., O.A.A., voluntary insurance and other programs are doing the job. We should be the first to suggest improvements where they are needed.

The component medical societies have a key role in diagnosing and solving local problems regarding medical care for the aged. This should be a high priority item. Important, too, is the providing of pertinent local information to the MSMS for action at the state level where necessary.

Public and private health and welfare agencies concerned with medical care programs need more of our leadership and participation than ever before.



Clinic Days Offer Postgraduate Education

Once again, the Michigan State Medical Society through its Committee on Postgraduate Medical Education will offer Clinic Day programs across the state. Cooperating in this extensive education project will be the two Michigan colleges of medicine and numerous county medical societies.

Plans for the 1961-62 locations along with suggested topics have been approved by The MSMS Council. The Committee is advancing the details now with local leaders to develop the fall programs.

* * *

THE COMMITTEE REPORTS that a clinic will be re-established at Petoskey. Interested persons in that area were interviewed and it was reported that the Petoskey-Charlevoix area doctors are eager for a renewal of their former program.

Possibilities of developing a center in the Thumb Area also is being considered by the Committee. It has been pointed out that doctors in that area cannot easily attend the other clinic programs.

* * *

ALTHOUGH FINAL TOPICS have not been determined and although various clinics select different topics, the following subjects are being considered: "Radioactive Isotopes," "Anesthesia, Old and New," "Pre and Post Operative Care," "Seizure Control," "Hemolytic Diseases of the Newborn" and "Obstetrical Infections."

Other suggested subjects include "Mental Retardation," "Chemotherapy of Hypertension," "Management of Elderly-Confused Person," "Casual Thyroid and Casual Goiter," "The 'Missed' Fracture," and "Visual Evidence of Neoplasm."

The following communities hosted clinic day programs last fall and/or spring—Alpena, Battle Creek, Bay City, Cadillac, Jackson, Lansing, Midland, Muskegon, Niles, Port Huron, Roscommon, and Traverse City—and also the following Upper Peninsula communities —Escanaba, Houghton, Iron Mountain, Ironwood, Marquette, Menominee, Sault Ste. Marie.

Although attendance figures may not always be complete, the Committee reports that a total of 613 participated in the clinic days last fall. The spring figure, with two less clinics, drew 483.

John M. Sheldon, M.D., Ann Arbor, is chairman of the MSMS Committee on Postgraduate Medical Education.

Following is a calender of the Clinic Day locations and dates for the Fall.

Alpena: Thursday, October 12
Battle Creek: Thursday, October 19
(Calhoun County Clinic Day)
Jackson: Tuesday, October 17
Lansing: Tuesday, September 19
Midland: Monday, November 13
Muskegon: Friday, October 20
Niles: Tuesday, October 17
Petoskey: Thursday, November 9
Port Huron: Tuesday, November 7

Roscommon: Wednesday, October 18
Traverse City: Thursday, December 7

Upper Peninsula:

Sault Ste. Marie: Monday, November 6
Escanaba: Tuesday, November 7
Menominee: Wednesday, November 8
Iron Mountain: Thursday, November 9
Ironwood: Tuesday, November 7
Houghton: Wednesday, November 8
Marquette: Thursday, November 9

Lansing Cooperative Efforts Explained at AMA Institute

An excellent example of "Community Action on Aging" was cited by Frederick C. Swartz, M.D., Lansing, at the 1961 Annual AMA Institute at Chicago for 400 medical society leaders and lay executives.

Dr. Swartz, chairman of AMA's Committee on Aging, illustrated case study of a new rehabilitation program offering both outpatient and inpatient services to handicapped persons, which was organized in Lansing, under the leadership of a local medical society in cooperation with other health and civic groups.

The Ingham County Rehabilitation Center, organized as a voluntary agency, represents a model for the conduct of a total rehabilitation program, said Dr. Swartz, including evaluation, treatment, teaching, research and vocational services, in association with local hospitals. Through a cooperative program with Rehabilitation Industries, Inc., a vocational rehabilitation workshop for handicapped persons, the program also encourages and utilizes the productivity of the rehabilitated handicapped. Medical policies and procedures of the rehabilitation program are directed by a medical advisory committee, appointed each year by the Ingham County Medical Society.

"The program is unique," Dr. Swartz said, "in that it represents an interdisciplinary team approach to the handicapped aged, and demonstrates how a completely separate rehabilitation service can move into a general hospital, and through cooperation and collaboration, adjust itself to overlapping spheres of service, influence and administration." Dr. Swartz also dealt with the transportation problems of the aged, and the research studies being done to alleviate these problems.

Important Voice

Question: The AMA has accomplished much in its fight against quacks, its drug council and other activities; how does the AMA communicate with its members?

Answer: The establishment of the *Journal AMA* has been the lifeblood and heart of the Association.

* * *

The matter of establishment of the *Journal* as the property of the Association was first proposed in 1852, when J. B. Flint, M.D., of Kentucky, proposed to amend the Constitution to provide for the establishment and maintenance of a quarterly journal. The gradual development of sentiment toward the publication of a weekly periodical culminated with the establishment of the *Journal AMA* in 1883.

Ever since its founding, the *Journal* has been a powerful voice of the medical profession in raising the standards of medical education, investigating the preparations and composition of drugs and pharmaceutical preparations, compiling and publishing an official directory of the profession and supporting one campaign after another for the advancement of medical science and the provision of medical care to all the people.

The *Journal* today has the largest circulation of any medical periodical in the world. It is mailed each week to more than 180,000 physicians.

The AMA also publishes 10 specialty journals and *Today's Health*, a health magazine for the public.

On Red Cross Program

Otto K. Engelke, M.D., Ann Arbor, president of the Michigan State Medical Society, participated in the Red Cross Statewide Conference in Flint, September 29-30. Doctor Engelke served as chairman and moderator at the Blood Program Workshop.

"I just read that when Herbert Hoover was president he gave all his salary back to the government. Now they got us all doin' it."

—Herb Shriner

MICHIGAN MEDICAL MEETINGS AND CLINIC DAYS

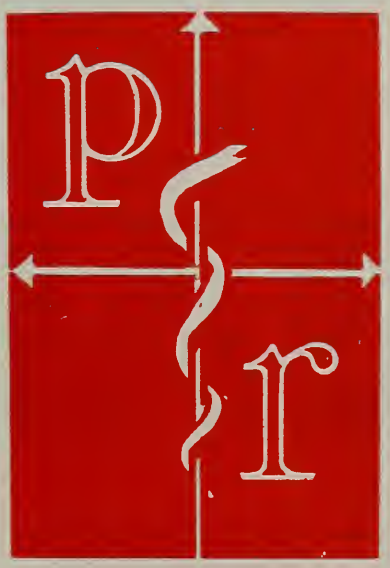
November 7-8-9	Michigan Academy of General Practice Annual Fall Postgraduate Clinic	Detroit
December 6	Michigan Regional Committee Annual Symposium on Trauma	Detroit
February 3	MSMS County Secretaries'-Public Relations Seminar	East Lansing
February 10	Michigan Heart Day	Detroit
Feb. 28, Mar. 1-2	Michigan Clinical Institute	Detroit

Medicine in Action

Programs Outlined at AMA Institute Chicago, August 31, September 1, 1961

By R. Wallace Teed, M.D., *Chairman, MSMS Public Relations Committee*

(This is the first of several installments of Doctor Teed's report to The Council of MSMS)



The name of the meeting was changed this year to "AMA Institute," because it was intended to do more than to cover Public Relations materials. About half of the program was devoted to a presentation of AMA activities, in an attempt to "stir up, fire up, and wake up" its membership, according to AMA President Larson.

The program consisted of three main parts: (1) Public Relations Aspects of our battle for Independent Practice; (2) Activities of selected Medical Societies in working with the Community; (3) Activities of the various programs carried on by the AMA.

A number of exhibits were available, pointing up certain features of talks that were given. For example, the USPHS had an exhibit on "Medical Self-Help Training Program" which illustrated the talk of Dr. Caruth J. Wagner (Chief, Division of Health Mobilization, USPHS). It featured a kit containing a projector, film strip and pamphlets on Fallout, hygiene, sanitation, vermin, artificial respiration, etc., which can be used to teach American families how to survive a national emergency and to meet their own health needs. These kits and program will be available in late 1961 for the use of state and local societies. This seemed to be a valuable program, and one which MSMS could use.

Supplementing this was an AMA exhibit on Emergency Medical identification, including dog tags, bracelets, et cetera, on which may be placed warnings of sensitivity, blood type, diabetes, and other information.

An AMA exhibit on "Careers in Medicine," containing booklets and other materials could well be used in the MSMS Medical Recruitment drive.

* * *

ESPECIALLY INTERESTING was the AMA Department of International Health Exhibit, showing how affiliate memberships, text books and subscription to Journals were being offered to Medical Missionaries. For interns, Medical Missionary service could be substituted for Military Obligations, and furloughed missionaries could be offered continuing Medical Education. This exhibit illustrated a point in Dr. F. J. L. Blasingame's talk, in which he stated that we should share our talents with the rest of mankind and be good samaritans. Work of this type could be an effective refutation of the common image of the physician as a person interested only in making money. I would recommend this exhibit as a possible part of the MSMS educational program.

An exhibit on "Effective Grass Roots Materials" contained several pieces published by MSMS in showing what can be done by Medical Societies in molding public opinion. Other AMA exhibits included "Medico-Legal and Ethics Publications," "Councils in Medical Service Publications," "Communications Division," and "Teen-age Nutrition."

The Illinois Medical Society presented an exhibit featuring a tape recording of the work of the Society, and a box of pamphlets with an invitation for requests from the public.

I. THE BATTLE

I was impressed by the contribution of Rev. Robert Varley (Salisbury, Maryland) who asked: "Are we fighting a battle we can win?" He broke the problem down into four parts: (1) situation, (2) problem, (3) strategy, and (4) tactic.

The situation is the *cult of collectivism*, seeking through legislation to socialize American medicine, industry, labor, education, religion and social life. Medicine is a prime target because these planners believe its training and insight represent the greatest threat to these "idiot ideologists."

The problem is that the pseudo-social planners are attempting to erect a socialistic superstructure on a democratic base. Only as medicine sees the problem in its complexity can it mount full scale war against the enemy.

* * *

THE STRATEGY CONSISTS of being aware of our allies, those who can act as our "Intelligence Corps" and provide aid, both active and reserve. We must win those in government medicine, academic medicine, research, hospitals, pharmacy and nursing if we are to win.

We must work with our own hands, and assume the mantle of leadership which medicine has worn in the past.

His conclusion: With men of good will and common determination, we can win.

This was a forceful presentation and warrants reprinting for the guidance of all our members.

Prof. Wm. De Mougeot (North Texas State University, Denton, Texas) gave an excellent evaluation of the various arguments used against socialized medicine. His presentation is one of the most logical which I have heard, and I believe that it would be useful for a meeting such as the annual Public Relations-County Society Seminar of MSMS.

Doctor De Mougeot's suggestion regarding time payments is one which I believe MSMS could well investigate as a means of handling larger accounts. In this way, we could put our emphasis on helping to solve problems rather than denying they exist.

* * *

THE MOST INTERESTING FEATURE of the panel on "How to Counter Criticism," to me, was the presentation on buying newspaper space, by Dr. C. N. Hyatt (Chairman, Public Relations Committee, Iowa State Medical Society). He pointed out that we can improve our relations with newspapers by buying space to tell our story, since advertising is the lifeblood of the press. In addition, there would be no editorial alteration of the text.

The Wayne County (Iowa) Medical Society presented a series of articles on medical organization, care, policy, et cetera, and found that the series was successful and the cost relatively low. I believe that MSMS could profit by this type of presentation, and that it might be more helpful than a similar series via radio. I would recommend investigation of this activity, both on the state and local levels.

II. ACTIVITIES OF MEDICAL SOCIETIES

Robert Conger, the young, aggressive, enthusiastic President of the United States Junior Chamber of Commerce from Tulsa, Oklahoma, indicated that here we have another ally in our battle, and one which should be recognized on the community level. Their health program is (1) to find out what the problems are, (2) what facilities exist, and (3) how the problems may be solved. The program is divided into such subjects as accidental poisoning, alcoholism, care of the aging, family health maintenance, rehabilitation, voluntary health programs and immunization, all of which are of interest to us, and would aid in presenting a positive program to the community. I would recommend that MSMS take an active interest in this organization.

Dr. Frederick C. Swartz, of Lansing, gave a beautiful presentation of the Ingham County rehabilitation center at Sparrow Hospital, illustrated with slides, which was very well received.

Dr. H. D. Gardner, Director of Medical Civics Course, University of Louisville Medical School, described a course in "Medical Civics" which is quite similar to the MSMS course in Medical Economics and Ethics, which has been going on now for some twenty years. At Louisville, the course has now been integrated into the curriculum which is not the case here.

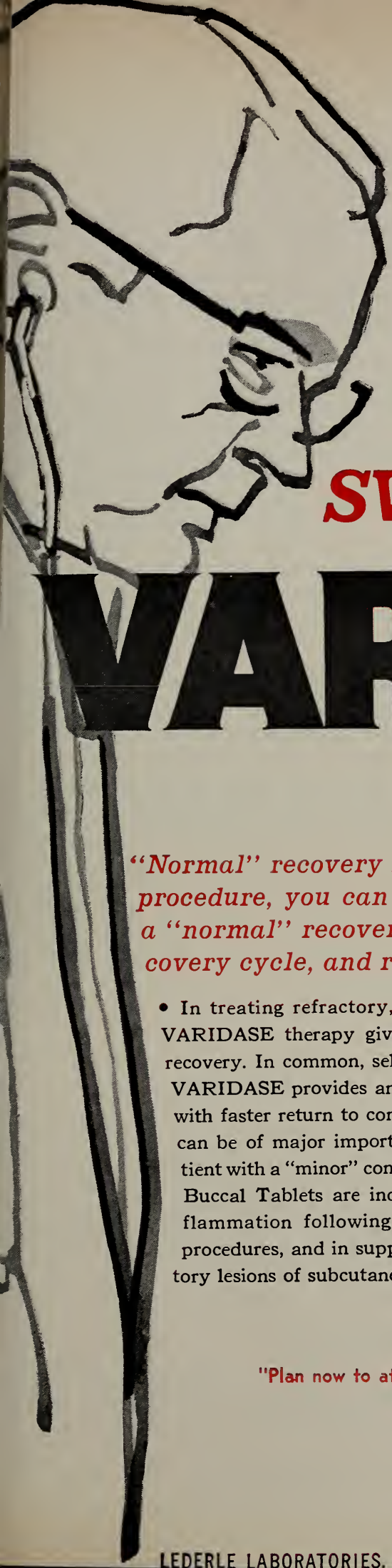
I would recommend that Dr. C. H. Ross, Ann Arbor, the present chairman of the committee handling the Michigan series, be suggested as a speaker for the AMA Institute next year.

The experience of the Pennsylvania Medical Society in dealing with labor has been so satisfactory, as detailed by Dr. W. B. Harer (Vice Chairman, Pennsylvania Medical Society Board of Trustees, that I would recommend that MSMS pursue a similar series of meetings with labor leaders in an attempt to clear away differences, and to find a common ground on which we can work for the benefit of the Community.

Dr. Harer made these suggestions:

1. Take the initiative in establishing contact.
2. Carry activities down to the grass-roots level.
3. Offer counter-proposals instead of rejecting their ideas.
4. Select Medical representatives carefully, attempt-

(Continued on Page 1264)



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Medicine in Action

(Continued from Page 1262)

ing to have men who put aside pre-conceived ideas and be receptive to new thoughts.

5. Treat labor leaders as equals.

6. Don't expect to resolve all differences. Limitations must be recognized.

* * *

WORKING IN THIS WAY, THE PENNSYLVANIA MEDICAL SOCIETY and the Unions began to understand each other's goals, eliminated distrust, reduced opposition, developed cooperation, to tolerate each other, and to realize that both groups were interested in the health care of older people. I believe MSMS could profit in the same way.

Dr. C. S. Lewis, Jr., Tulsa, Oklahoma, spoke on an international health program carried out by Tulsa physicians in cooperation with some of the local churches. The group organized and collected a fund which made it possible for five local physicians to go to a Presbyterian Hospital in Miraj, India, for periods of six to eight weeks. Later, others plan to participate in this program which

1. Provides help where needed
2. Demonstrates Christianity in action
3. Demonstrates American concern for people
4. Exchange ideas with other people.

I might add that the Christian Medical Society has in the past year, also sent out nearly a dozen men to countries like Korea, Congo, and Central America, helping in its own way to share with others the blessings with which God has so richly endowed our country.

USPHS ATTITUDE TOWARD HEALTH SERVICES

. . . Significant changes have taken place in American attitudes, including the attitude toward health.

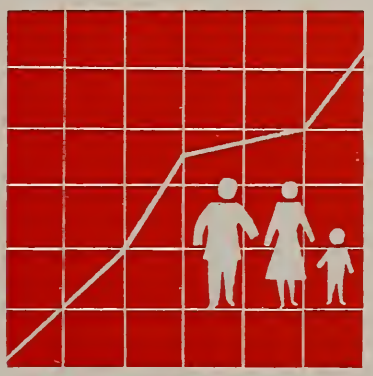
Increasing numbers of Americans today are demanding more security and, with this, more health services.

More and more Americans are willing to forego other satisfactions in favor of health insurance; good health is now regarded as another "inalienable right."—"Areawide Planning for Hospitals and Related Health Facilities." Report from U. S. Public Health Service.

BIRTH RATE UP

About 40,000 more babies were born in the U. S. in 1959 than in 1958, according to Public Health Service. There were 4,295,000 live births in 1959, of which 51 per cent were births of a first or second child.

Say you saw it in the Journal of the Michigan State Medical Society



Average Annual Health Costs Reported at $539

For some 12 million persons who itemized expenditures on their 1958 Federal income tax returns, their average medical and dental expenses were $539, according to an analysis by Health Insurance Institute. The average health expense deduction was about $330.

The average expense figure of $539 would include premium payments for health insurance policies, drugs and other medicines, hospital charges and physicians' and dentists' fees.

Persons who earn more spend more for health care services and products, the returns indicate. Average expenditures of $523 were reported by taxpayers in the $5,000-$8,000 income bracket, and $862 in the $10,000-$15,000 bracket.

Accredited Hospitals Serve 83 Per Cent of Hospital Patients

Eighty-three per cent of all hospital admissions are to hospitals accredited by the Joint Commission on Accreditation of Hospitals, according to the annual guide issue of *Hospitals*, journal of the American Hospital Association.

The tabulation shows that while only 54.4 per cent of all hospitals are accredited, such hospitals account for:

Some 85.7 per cent of all hospital births; 61.7 per cent of all beds; 60.5 per cent of the average daily number of patients; 80.7 per cent of all hospital employment; 81.8 per cent of total expense for operation of all hospitals; and 78 per cent of all hospital assets.

Sees "Mother Hen" Replacing the Eagle

Americans have substituted the image of a mother hen for the American eagle. Washington today constitutes the biggest employer, the biggest manager, the biggest consumer, the biggest stockholder and the biggest property owner. . . . If the present trend continues, the federal government itself will become the biggest threat to America's eminently successful free enterprise system.

—Harold W. Handley,
Governor of Indiana

AHA Proposal to Congress

The American Hospital Association has made a flat offer to Congress to administer the Kennedy Administration's proposed medical-care-for-the-aged program at state level through existing Blue Cross plans, provided the Federal Government keeps hands off such Blue Cross administration.

Otherwise, said AHA president Frank S. Groner of Memphis, Tenn., who made the offer, AHA must oppose the bill on the grounds that "government as purchaser of so much hospital care would exert the power of purse in ways detrimental to the interests of hospital patients."

Quarterly Blue Shield Payments Set Mark

The nationwide Blue Shield Plans paid out more than $206,000,000 for surgical-medical care rendered to members during the first three months of 1961. The National Association of Blue Shield Plans reports the $206,321,765 paid to the medical profession represented a record high for a three-month period.

The national association also indicated payments to the medical profession over the past decade had increased from approximately $165,000,000 in 1951 to the 1960 figure of $731,131,187.

Blue Plans Serve Millionth Federal Employee

The one millionth government employee has picked Blue Cross-Blue Shield under the Federal Employees Health Benefit Plan.

Government employees comprise the biggest group in the world with a common employer protecting themselves against the cost of hospital and medical care.

Blue Cross-Blue Shield with at least 54 per cent of the government workers enrolled, has more than the other 37 plans combined.

In Michigan the figure is even higher. Some 61 per cent of federal employees have chosen Blue Cross-Blue Shield; 13.5 per cent have picked the Aetna commercial insurance plan and a little over 25 per cent are enrolled under employee organization plans.

Walter J. McNerney, president of the Blue Cross Association, and Dr. William Howard, president of the National Association of Blue Shield Plans, both point out that a unique feature of the federal Civil Service Commission is offering employees a wide choice of 38 programs, with the decision entirely up to them.

Says Conferences at Resorts Won't Preclude Deductions

Commissioner of Internal Revenue Mortimer M. Caplin recently denied that legitimate expense deductions for conventions and business meetings are being disallowed because the business activity takes place at a resort area.

The Commissioner had received information that businessmen, associations and other groups were concerned as to whether, under existing law, legitimate expense deductions, particularly those for conventions or business meetings, are being disallowed because the business activity takes place at resorts.

There is no reason for such concern, the Commissioner said in reiterating IRS policy in this area. He added: "While it is true that we have intensified our audit activity in the travel and entertainment expense area, there has been no change in the concept of what constitutes a deductible expense. Those expenses which are clearly shown to be for business purposes will continue to be allowable under existing law."

Disallowances, he said, are properly made to eliminate wives' and children's expenses, expenses of side trips, vacations purported to be business trips, and for lack of substantiation of expenses incurred.

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A Geriatrics Committee at Work

Willis W. Atwell
Grand Rapids, Michigan

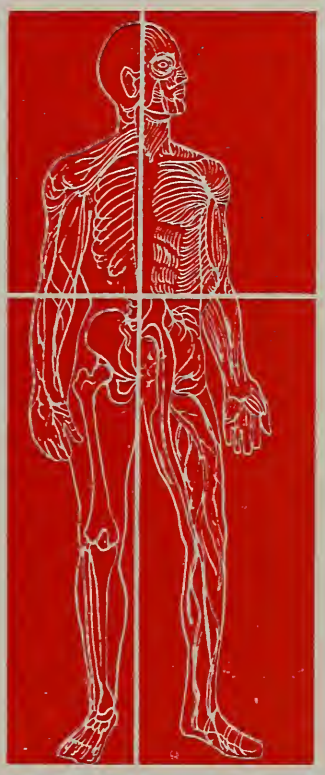
THE WHITE HOUSE CONFERENCE, and the regional preparatory meetings such as the one held in Lansing, devoted considerable time to a search for a pattern of community organization which would focus on the aging segment of population explosion. Evolution of such a community organization in Grand Rapids and Kent County began with programs and studies by the University of Michigan's Division of Gerontology in 1949-1952, with the full cooperation of the Council of Social Agencies. Exploration as a Council committee continued slowly until a plan was evolved and finances secured from the Junior League and W. K. Kellogg Foundation for an experimental community program. In February 1959, The Coordinating Council for the Aging of Grand Rapids and Kent County began an action program with a full Board of Directors and an executive.

The Board is representative of the elements of the community essential to a coordinating program. Participating are representatives of the Junior League, business, industry, labor, major religious groups, the legal and medical professions and the directors of the health and welfare departments. It is with the participation of the medical profession that this report is concerned.

There was agreement that any community organization of services for older people must be tied closely with the Geriatrics Committee of the Kent County Medical Society, if the program was to be meaningful and soundly geared to the needs of the people it should serve. Kent County's Coordinating Council for the Aging with this cooperation has built a program based on this premise.

One of the Council's projects was the compilation of a directory of services, and arrangements were immediately made by the chairman of the Geriatrics Committee to have it sent by the Medical Society to each member. Similarly, the Geriatrics Committee has kept the Council's program and projects before the Society's membership through regular reports in the JOURNAL and at meetings.

This inter-play of organizations has also proved effective in training programs. Members of the Geriatrics Committee served as resource people in the training program for volunteers to work in nursing homes in a diversional therapy project. Working with the Coordinating Council, in addition to the Geriatrics Committee, were the Junior League, Welfare Department, nursing homes, Health Department, and the local chapter of the National Association of Social Workers. The diversional therapy experiment proved of value and it is expected the Federation of Women's Clubs will carry on with it this fall. Through the offices of the Geriatrics Committee all nursing home patients were cleared for approval with their own physicians



Mr. Atwell is Executive Director of the Coordinating Council for the Aging of Grand Rapids and Kent County.

before the volunteers worked with them.

Another training program in which the Geriatrics Committee participated has been in training of home aides to care for elderly ill or disabled persons in the patients' own homes. After cooperating in the planning of this project, the Committee furnished members to cover the relationship of the home aide to the doctor, the psychological aspects of old age, and the use of simple rehabilitative exercises under a doctor's orders. In addition, home aides were given the Red Cross "care of the sick and injured" course, instructed how to use the Fire and Police Departments in emergencies, exposed to diversional therapy by an occupational therapist, given safety instruction by the Safety Council, were made acquainted with Health Department services, given an intensive course in food preparation and home management, and shown available community resources. As a result of two classes, there are now twenty-five trained home aides on the job.

Second only to health matters in the Coordinating Council's concern has been housing. Here, too, the Geriatrics Committee has been helpful. In working with the Milner Hotels, Inc., on the establishment of a low-cost residence for older people, as a combined effort of private enterprise and community services, the Committee was helpful in working out a physician call system so that ill residents might get immediate attention. Members of the Committee are also working with the Council on a "health center" in the hotel to be staffed by volunteer registered nurses. This offers a place for examinations to be made. Because of the Committee's interest, it has been possible to use this as a facility for the return of rehabilitated older people to community life under minimum supervision, but with planned activities. Among the groups furnishing volunteers in the recreational program is the Medical Society Auxiliary. By the way, room and meals in this renovated structure, where each room has its own bath, totals $86 per month.

In another hotel conversion (the Manger-Rowe), with which The Council is cooperating, members of the County Society are cooperating in furnishing a health report on the potential residents, since this is to be a facility for the well older person.

Close cooperation between The Council, Geriatrics Committee, County Society, and Health Council resulted in a grant of $10,000 from the Grand Rapids Foundation for a study of convalescence, chronic illness and rehabilitation, administered by the planning division of United Community Services. The study completed last fall by A. J. J. Rourke, M.D., of New Rochelle, New York, is in the hands of an implementation committee on which the Coordinating Council is represented by a member of Geriatrics Committee.

Similarly, the Coordinating Council, Geriatrics Committee, Health Department, Welfare Department and Michigan State Health Department cooperated in the adult screening project described in detail in this issue. The same organizations also cooperated in a study of possible further improvement of nursing-home care and a program recommending establishment of restorative techniques based on an in-service training program. This, coupled with increased nursing home fees, was adopted on the local level. To date, funds for the base budget have not been secured.

Ever since the University of Michigan's Division of Gerontology made its initial studies in Grand Rapids in 1952-1953, there has been an annual Senior Skills Show in which older people exhibited their handiwork. Attendance has been good and it appeared to present an opportunity to do some educational work. Therefore, last year with the assistance of the Geriatrics Committee, a Health Fair was added. Included were most of the major voluntary health organizations with a message for older people, plus an animated exhibit placed by the Medical Society.

As might be expected, some programs do not directly involve the Geriatrics Committee, but the Committee has been enthusiastic in its support of those programs offering activities to older people for any therapeutic by-products there might be. Some of these have been the registration for voting of shut-ins prior to the presidential elections last fall; extension of the Recreation Department's decentralized program into unserved areas by organizing groups; publishing a weekly calendar of events of interest to older people in the newspaper and presenting a weekly radio program for older people; initiating an information, referral and counseling service; and offering assistance to people with problems encountered as the result of being displaced by the inter-regional highway program, as well as working with urban renewal on relocation problems.

These programs have been developed during the past two and one-half years and have required the combined efforts of many to make them possible, but such an active program in such a short time would not have been possible without the cooperation and backing of the Geratrics Committee of the Kent County Medical Society, under the chairmanship for two years of Ralph L. Fitts, M.D., and now headed by Michael E. Ellis, M.D. Grand Rapids' older people can truly thank the doctors on the Committee for many of the services they now enjoy.

Medical Evaluation of 100 Welfare Applicants Between the Ages of Sixty and Seventy

Winston B. Prothro, M.D., F.A.C.P.M.
Warren B. Mason, M.D.
Grand Rapids, Michigan

SEVERAL YEARS AGO, the problem of illness in the indigent elderly population was discussed by various interested groups on a State level. It was proposed that all applicants for public funds should have a complete physical examination with the underlying thought that illness alone might have caused the need for public aid. Proper care, therefore, might reduce the welfare expense. This apparently was attempted on a minor scale in one other Michigan city but was unsuccessful. More recently, attention has been focused by both professional and lay groups on the medical care of elderly citizens and interest has again entered in this problem of evaluation of the medical status of elderly indigent patients. This question was discussed in the Coordinating Council for the Aging of Grand Rapids and Kent County by various members of this group, including representatives of City and County Health Departments, the Kent County Medical Society and Dental Societies. After discussion of the aims and need for such a study, and when funds were made available through several agencies, this study was instituted in the City of Grand Rapids.

The original purpose set forth was to determine the number, type, and severity of physical deviations in a sample group of *apparently well* public assistance applicants. This study was also to serve as a means of exploring the practicability of screening programs to discover disease and prevent complications. Finally it was to provide information relating to socio-economic problems related to chronic disease detection, prevention and control.

We chose to examine 100 people between the ages of sixty and seventy who applied to the Kent County Department of Social Welfare for public assistance. In order to find enough candidates, the records were utilized from April 1959 to September 1960. Sixty-six applicants were women and thirty-six were men. Seventy-one were white and twenty-nine non-white. Thirty-four had no physician and were unable to give a physician's name for reference. Table I shows the various categories of welfare applicants. It is interesting that, in spite of assurance about the motives of this survey and that the examination would not jeopardize the welfare application, less than one-half of the people of a total 249 were willing to take part in the examination. (I should add that the most common reason given was that they felt they had adequate care by their own physician.) The inability to take consecutive cases will add some bias to our findings. The exclusion of homebound and nursing-home patients will certainly reduce the number of serious illnesses. However, the original intent of this survey was to examine apparently well applicants. The money utilized in this survey was made available through the State Health Department from Federal grants-in-aid funds to the County Health Departments and additional aid was received from the American Cancer Society and the local branch of the State Laboratory.

TABLE I. CATEGORIES OF WELFARE APPLICANTS

Old Age Assistance	
Applications from April 1, 1959 to September 30, 1960	783
Ineligible because of age or health status	575
Possible contacts for physical exams	208
Contacted but not interested	127
Physicals completed	81
Direct Relief	
Applications from September 1, 1959 to August 31, 1960	67
Ineligible because of age or health status	26
Possible contacts for physical exams	41
Not interested	22
Physicals completed	19

Method

The examination was made in the medical facilities of the Tuberculosis Clinic of the Grand Rapids Kent County Health Departments. The nurse supervisor, x-ray technician, medical aide and public health nurses

Doctor Prothro is Director of the Grand Rapids and Kent County Health Department.

TABLE II. DISEASES

	Known	Unknown
Heart and Vessels		
Labile Hypertension		2
Hypertensive Vascular Disease	5	10
Hypertensive Cardiovascular Disease	13	7
Hypertensive Arteriosclerotic Heart Disease	5	7
Arteriosclerotic Heart Disease	4	12
Angina	3	7
Cor Pulmonale		1
Rheumatic Heart Disease	2	
Syphilitic Heart Disease		1
Myocardial Aneurysm (EKG)		1
Auricular Fibrillation		1
Congestive Heart Failure	5	1
Organic Heart Disease Type undetermined		1
Generalized Arteriosclerosis		2
Arteriosclerotic Retinopathy	1	1
Arteriosclerotic Peripheral Vascular Disease		3
Leriche Syndrome		1
Postural Hypotension	1	
Intermittant Claudication		1
Possible Aortic Aneurysm		2
Metabolic		
Gout		2
Malnutrition	1	1
Diabetes Mellitus	9	14
Elevated two-hr. postprandial blood sugar >130		14
Diabetic Complications	2	
Nontoxic Nodular Goiter		2
Thyroid Adenoma		5
Colloid Goiter		1
Hyperthyroidism		3
Hypothyroidism		1
Hypocholesterolemia (Probable)	1	2
Question of Cushings Syndrome		1
Question of Hypoventilation Syndrome		1
Pulmonary		
Senile Emphysema	4	11
Chronic Bronchitis	4	4
Bronchial Asthma	1	
Bronchiectasis		2
Fibrocalcific Disease—x-ray findings		2
Density in Lung—x-ray findings		2
Old Tuberculosis	3	
Possible Cancer of Lung		2
Eye-Ear-Nose		
Increased Intra-ocular pressure (greater than 24.4)		13
Glaucoma	1	1
Cataract	3	2
Corneal Scar	2	
Blindness	2	
Decreased Visual Acuity	2	
Ectropion	1	
Eye Injury	1	
Vitreous Opacities		1
Impaired Hearing	8	
Menieres Disease		1
Vasomotor Rhinitis	1	
Leukoplakia (Mouth)		1
Blood		
Anemia	2	5
Polycythemia		3
False Positive Serology		1
Weakly Reactive Serology		2
Late Latent Syphilis	2	
Reactive Kahn		2
Neurologic		
Peripheral Neuritis		2
Probable Mental Disease	1	5
Chronic Anxiety	3	
Old Hemiparesis	2	
Probable CNS Lues		2
Possible Spinal Cord Tumor		1
Miscellaneous		
Varicose Veins	14	
Dental Caries (Severe)	9	
Breast Mass	1	1
Splenomegally		1
Bone and Joint		
Osteoarthritis		
Generalized	5	
Lumbosacral spine	14	3
Cervical Spine	9	
Shoulders	4	
Knees	16	1
Hands	7	
Fracture Deformity Leg	1	
Gibbus Deformity of Spine	1	
Osteomyelitis-Skull		1
Charcot Joint		1
Pulmonary Osteoarthroperthy (?)		1
Knee Injury (? Lat. Ligament)	1	
Probable Compression Fracture (T 9-10)		1
Genito Urinary		
Cystocele	12	13
Rectocele	2	4
Stress Incontinence	8	
Uterine Descensus		1
Uterine Fibroids		3
Vaginal Stenosis		1
Pruritus Vulvae	1	
Labial Cyst	1	
Urethral Stricture		1
Benign Prostatic Hypertrophy		5
Prostatitis		1
Scrotal Mass (Incl. Testicular)	1	2
Cancer of Cervix		1
Trichomonas Vaginitis		1
Cervix Erosion		1
Cervix Polyp		1
Arteriolonephrosclerosis		1
Pelvic Mass		2
Skin		
Senile Keratoses (? Malignant)	1	1
Erythema Multiforme	1	
Infected Callous (foot) in Diabetic	1	
Intertrige	1	
Housewife's Dermatitis	1	
Gastrointestinal		
Obesity	28	
Irritable Colon	9	1
Gastritis	1	
Cholecystitis and/or Cholelithiasis	2	
Gastrointestinal Complaints	4	
Possible GI Malignancy		3
Diverticulosis	1	
Anal Stenosis	1	
Hemorrhoids	8	2
Alcoholism	1	
Hernia		
Ventral	3	1
Incisional	1	
Inguinal	2	1
Submandibular Mass (Probable Salivary)	2	
Probable Cholecystitis and/or Cholelithiasis		7
Possible Ulcerative Colitis		1

who are regular personnel of this Clinic were utilized in their various capacities for the examination. Numerous forms, tabulation sheets, follow-up letters (including letters of information to the local physicians) were prepared through the clinic, and the records of the survey were kept in this office.

The examination consisted of the following: medical and social history by the social worker and the examining physician; complete dental survey by the members of the Kent County Dental Association; complete physical examination including optic tonometry, rectal and pelvic examination. Laboratory work consisted of the following: chest x-ray, electrocardiogram, tuberculin skin test, Kahn test, cervical cytology (through the American Cancer Society), hemoglobin, two-hour postprandial blood sugar urinalysis (without microscopic), and stool guaiac.

Findings

It is best to have in mind that this type of examination should be compared to the first visit of any patient to a physician for a complete physical examination and preliminary laboratory work. One can realize then that many positive diagnoses could be made at the end of the first visit, the rest were tentative diagnoses and could be substantiated only through further laboratory work and follow-up studies which were not part of this survey We were forced to list some diseases, therefore, as probably serious conditions and in need of further investigation. This type of survey would naturally be weighted toward those diagnoses which can be made by inspection and simple laboratory procedures. Table II lists these diseases.

Discussion

The number of serious diseases in this age group is quite striking. Certainly this is a select group and already biased by several factors previously outlined. Of the sixty-six women, there were two positive cervical cytology tests, one of which was negative on two or three repeat examinations; the other patient had a positive cervical biopsy and has since had a hysterectomy. There were fourteen unknown diabetic patients and fourteen other patients with a two-hour blood sugar elevation greater than 130 mg. per cent. This, of course, is not diagnostic of diabetes but would suggest further study. Disregarding non-specific T-wave changes, there were forty-six abnormal electrocardiograms. Obesity and hypertension were two common abnormalities and are good examples of the type of diagnosis which can be made with some certainty on the first examination. There were many patients with suspected gastrointestinal abnormalities, even malignancies. No rectal carcinomas were found and it is somewhat surprising that in this age group there were no obvious skin cancers and very little difficulty with prostatitis or carcinoma of the prostate was noted. Only six patients were thought to be in excellent health.

TABLE III. ELECTROCARDIOGRAPHIC FINDINGS

Left Ventricular Hypertrophy	7
Left Ventricular Hypertrophy with Ischemia	5
Old Anteroseptal Infarct	5
Old Anterior Infarct	2
Anterior Wall Ischemia	6
Old Subendocardial Infarct	1
Probable Old Posterior	3
Posterior Wall Ischemia	4
First Degree Heart Block	4
Complete Right Bundle Branch Block	3
Complete Left Bundle Branch Block	2
Auricular Fibrillation	2
Myocardial Aneurysm	1

We have been unable to find any similar studies with which to compare our results. As has already been suggested, it is difficult to determine what diseases are known and unknown and furthermore we were left with a category of suspected serious disease that could not be placed under any particular category. We discovered 238 diseases not previously known to patients and confirmed 270 known diseases. This would seem at first to be an indictment of the medical profession and the medical care these patients have received. However, the majority of these patients considered themselves well and had not required recent medical care. It is also interesting to note the similarity of findings in this group of public assistance applicants to a more thorough study by the University of Michigan on their faculty members covering a wider age range in a much higher economic bracket.[1,2]

There was some controversy throughout this entire study as to how we could answer the questions set forth in the original purpose. We did determine the numbers and types of abnormalities up to a certain point, but many of the diagnoses were only tentative. We did show that a study of this sort could be carried out on a voluntary basis with some welfare applicants. We could not make the absolute assumption that it would be valuable to compel all welfare applicants to have such an examination. We were able to make some assumptions about the prevention and control of chronic disease in this age group. There is no doubt that proper therapy, even at this age, of many of these diseases could easily save prolonged periods of mor-

bidity and reduce the mortality for certain diseases in this group. It is impossible to estimate in any way the money that a county might save through the proper treatment of hypertension and the prevention of even one stroke. It is possible that public funds saved in this way could finance the preventive medicine program.

TABLE IV. FOLLOW-UP OF 100 PATIENTS

Patients regarded as having only minor illinesses not requiring intensive care	29
Patients needing follow-up who had contacted own physician	36
Patients who did not return to physician but were seen by visiting nurse	35
Returned for care after nurses visit	16
Urged to return—but results not known	6
Felt no need for medical care	6
Not located	6
Died	1

After the examination, we made no attempt to counsel the patient. Some obvious serious illnesses requiring immediate care were urged through the Welfare Department. A summary letter of the findings, including a tentative diagnosis, was sent to the family physician or welfare physician in all instances and the patient was urged to contact these doctors for their follow-up care. A follow-up letter was sent to each of the physicians and some contact attempted with each of the patients to determine if they were under proper care. Many of these people were not seeking medical attention because they did not feel it important, others because they did not suspect any disease; some felt they could not afford it and were unaware of some of the ways open to them to get care through local hospitals or welfare. We are attempting to do a careful follow-up over a period of one year and plan to report this at a later date. Results are shown in Table IV.

An interesting suggestion regarding further surveys of this sort has been made by a member of the evaluation committee; that a similar study of the same number of patients in this age group be carried out using only technicians to do all the various mechanical parts of the history and laboratory studies, with the physician passing only the final judgment on the collected data in order to reduce the cost and time involved. Of course, this would reduce such a survey to a case-finding system in an effort to pick out serious disease only and help secure immediate care in order to reduce the future cost. However, this approach would rob these patients of a real preventive medicine approach and perhaps mislead them as to their health status.

Conclusions

1. A complete physical examination with detailed history and screening laboratory work was carried out on 100 welfare applicants in the 60-70 year age group.
2. There is a large reservoir of known and unknown disease in this group.
3. The numbers and types of disease in this group seem comparable to those found in similar age group at higher economic levels.
4. Although it is difficult to estimate by any parameter, it can be surmised that proper treatment even at this stage could prevent some complications of the diseases found and thereby decrease morbidity and mortality in this group.
5. Without complete follow-up including appropriate studies, there is no doubt that other serious diseases including malignancies were present in this group but not detected.
6. One of the problems in our society today is to try to carry out similar examinations on all citizens with the same degree of completeness and at as low as possible cost.

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Find Tuberculosis Decline

A steady 10-year decline in the number of new cases of active tuberculosis discovered among Veterans Administration patients admitted for treatment of other diseases has been reported by the Veterans Administration.

The rate in the Veterans Administration tuberculosis case-finding program, which excludes hospital patients admitted for tuberculosis, has declined from 58 per 10,000 in 1950 to 10 per 10,000 in 1960.

The Challenge of Aging

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IN SOME CIRCLES, too much attention has been directed toward the so-called difficulties and hardships of aging when, in reality, more attention should be focused on the opportunities and responsibilities in aging—or what might be called "the challenge of aging."

The majority of persons grow old rather gracefully. They take care of their own affairs, do their work, pay their taxes, have a certain amount of recreation and enter into various community activities as time, health and inclination permit.

The way to grow old most gracefully is to continue working as long as health permits and generally this can be maintained for a long time through good medical counseling.

If retirement becomes a reality (either compulsory or voluntary), the retiree should continue to keep active mentally or physically or both. Reading, studying, writing and speaking about a wide variety of subjects are open to any citizen who might apply himself. Vegetable and flower gardening, lawn care, painting and minor repairs around the house should keep a retired person rather busy much of the time.

I am a practicing physician first of all but I study and write and speak about anthropology, archaeology, ancient man, North American Indians, Chinese art, philosophy, radioactivity, and aging to keep from getting old.

One of the reasons for writing this paper is to seize the opportunity to meet the challenge of aging personally in a forthright manner by writing about it, pointing out some of the pitfalls that may trap the unwary and indicating some methods whereby the later years may be productive, fruitful, eventful, interesting and meaningful to myself while contributing something to my fellow man.

Youthful attitudes presage a person's approach to aging. Those who live an active life and find an interest in everything around them, can face the future with composure. Those who have been indolent have a limited horizon. As the years roll by and a person becomes less far-reaching in his activities, there should be a continual awareness of current events both at home and in world news.

The productive working years must also be the productive thinking years. If we do not try to broaden our knowledge, experience and interests, we cannot hope to grow old gracefully. A rewarding life is one in which an individual has experienced many things and learned something from each encounter. The formative years of youth must be inquisitive years of learning, training and re-learning as knowledge changes to furnish a background for the later years. All the things learned in a long, busy, productive life should be carried over into the less productive years. Youth has verve but age has dignity and serenity.

Old ties should not be broken thoughtlessly. Moving to Florida or California and thereby separating from old friends is a bid for dissappointment and loneliness. Remaining in the old environment seems more desirable, except for cause such as asthma, arthritis, coronary disease or a group of friends moving to a colony in a warmer climate. We can take up new interests, study new subjects, help others to help themselves toward a better approach to an interesting life, and undertake some of the things we have been promising ourselves to do when we had time.

If a person is occupied at least part of the time with some purposeful activity, subsequent leisure will be more appreciated and have more value. Rest has little to offer unless preceded by a little work. Painting, sketching, golf, poetry, or fictional or factual magazine articles might be called fun time or leisure-time work.

If money is a factor, many small services can be performed: companion, telephone answering, tutoring school children, sewing, typing and temporary care of children. If money is not a problem, there are many volunteer services: Red Cross; social, church and political organizations; reading to blind or sick persons—to name a few.

Rambling references to the past generally should be avoided except that one should be willing to discuss past events with those who shared them or with

really interested persons. A concern with good grooming helps to keep one active.

The Cycle of Life

The natural sequence of life is cyclic. All living things follow a general pattern of coming into existence, a stage of immaturity, a period of maturity, a time of decline and then passing out of existence. The sequence of aging is inevitable and represents a challenge to manage it in the most useful manner.

Man is in nature and yet transcends nature by his unique ability to learn and to teach extant knowledge, thus making it possible for each generation to stand on the shoulders of all previous generations. Man is part of nature albeit he is a dramatic and singular part of it. His kinship with other living creatures of the earth is implicit in the sequence of aging for it is quite similar to that of all others.

Man is primarily the product of his heredity. He is secondarily the product of his culture. The implication is sequential rather than consequential. If he has opportunities for higher education, exposure to the principles, ideas and methods of persons of superior intellect, and a natural or acquired ability to absorb, to understand and to make his own the principles of scientific inquiry, the ideas of logic and ethics and the methods of study and utilization of modern knowledge, he should be joined in the ranks of the most advanced culture of his time.

The cycle of life is an assured and natural sequence for all human beings. All persons are aware that the span of life is ultimately limited. Some fail to accept the challenge to make the most of life during immaturity and maturity when it is within their power to do so. They have difficulty in conceiving of themselves as becoming non-existent at some future time.

Many opinions have been written about the good life and how it should be lived to the greatest advantage, ranging from the practical philosophy of Confucius of the sixth century B.C., to some rather esoteric modern concepts. The promotion of some organizations and schemes is almost entirely for profit and little less than a racket.

There would be little service in describing or comparing these widely diverse opinions. They are available to all men who read. In the long run, every man tends to take unto himself what is intellectually or emotionally acceptable to him unless, of course, he has been completely indoctrinated with a system of ethics, morals, philosophy or religion before he reached an age of discernment. In the end, every man must be his own philosopher.

Aging has been described as beginning at birth and continuing throughout life. It should be a process of continually maturing both physically and mentally. The challenge is to maintain high physical and mental capabilities by keeping active. This does not mean the development of muscles suitable for champion weight-lifting nor the intellectual activity that might be involved in solving the long-disputed method of light propulsion. It means, rather, a golden mean of physical exercise in moderation and the mental activity that might be conducive to understanding the quantum theory.

Metabolic change and exchange are the processes of growth and healthful living, therefore, we must undertake new ventures, learn new skills, and entertain new concepts and attitudes. A rigid pattern of life does not contribute much to development. When developmental changes cease to take place, senescence supervenes.

Report on Lost Days

During the year ending June 30, 1960, illness and injury caused the American people to stay home from work, stay in bed, or otherwise cut down their usual activities for an average of sixteen days per person, including six days of bed disability. These statistics are about the same for the year 1958-59.

These figures come from the latest in a series of published statistical reports of the Service's National Health Survey. They apply to the civilian population of the country exclusive of persons confined to long-term institutions.

The new report also shows that during the year ending June 30, 1960, more disability was experienced by women than by men. People over forty-five had more disability days than did younger persons, with the rate increasing sharply with advancing age.

People who live in rural farm areas of the country reported more days of disability, on the average, than those living in urban and rural-nonfarm areas.

Those in the lowest income groups reported the highest rates of disability, and the number of disability days dropped consistently with rising income.

Saginaw County Rehabilitation Program for Indigents

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Saginaw, Michigan

THE GOAL of the program is to offer the patients maximum opportunities for total or partial rehabilitation or at least independence in self-care to assure a greater degree of self-reliance. Although some strides have been made, it is recognized that the problem is difficult and complex because the group of sixty-five years of age, while representing only 10 per cent of our population, has a much larger incidence of long-term illnesses. In addition, a substantial segment in this group is dependent upon the County, State and Federal Governments to maintain the minimum standards of living or "Life's Necessities."

History

Until three years ago, the Saginaw County Hospital did not have a Rehabilitation Program for long-term patients except for tuberculosis patients. Some reluctance had to be overcome about starting the Rehabilitation Program for the aged on the part of the Board of Supervisors, the Welfare Department and even the physicians. However, a fifty-bed Unit and Rehabilitation Center became operative on September 3, 1958, as a part of Saginaw County Hospital. One of the important factors in its success was the creation in 1958 of a Geriatrics Committee by Dr. Edwin Galsterer, President of the Saginaw County Medical Society, which was given the responsibility of reviewing the program, development of criteria, and promotion of the professional interest in this program. The cooperative efforts of the Geriatrics Committee have contributed greatly to the successful operation of the Rehabilitation Center.

Program

Saginaw County Hospital is a fully accredited 275-bed hospital for the care of tuberculosis, communicable disease, chronic disease and mental patients. Income is derived from State Tuberculosis Subsidy; hospitalization of out-of-county tuberculosis and contagious patients; the Social Welfare Board payments for hospitalization of indigent chronic disease patients, Blue Cross, county tax appropriation, payment for private communicable disease cases, Veterans Administration receipts, et cetera.

In line with the established policy of the Board of Supervisors, only indigent patients are admitted to the Chronic Disease Service, upon authority of the Social Welfare Board when requested by physicians. Although the Chronic Disease facility could occasionally admit private patients, the medical profession was reluctant to encourage this policy. Until additional beds are available, and until the admission policy changes, admission to this service will be restricted to indigent patients. The treatment of the patient is guided by the family physician or by a full-time hospital physician with special interest in geriatrics, while the Rehabilitation Program is supervised by a team of physiatrists from the University of Michigan. Through James Rae, M.D., George Koepke, M.D., Leonard Bender, M.D., and Edwin Smith, M.D., one physician visits the County Hospital three or four times a month to counsel the medical and paramedical staff members, and to prescribe for the rehabilitation needs of the patients.

Staff conferences are attended by the Medical staff, the physical therapist, occupational therapist, home-nursing coordinator, public health nurses and occasionally by other practicing physicians. When necessary, speech correctionist, psychologist, and counselor in vocational rehabilitation are in attendance.

All patients' progress is reviewed at the Staff conferences every six weeks or oftener when indicated. If within three months a patient does not show any evidence of rehabilitation potential, the patient is transferred to a medical-care facility, nursing home, or to a home situation.

From September 3, 1958 to June 30, 1961, 325

Doctor Volk is Medical Superintendent and Doctor Maurer is Chief of Medical Services, Chronic Disease Unit, Saginaw County Hospital, Saginaw, Michigan.

patients were admitted to the Chronic Disease Unit of Saginaw County Hospital. Some pertinent information about the group is shown in Table I.

TABLE I. SAGINAW COUNTY HOSPITAL CHRONIC DISEASE SERVICE

Patients admitted	325
Patients discharged	195
Patients expired	79
Still hospitalized (As of July 1, 1961)	51
(Number of Hospital Days for the period: 43,038)	
Patients Admitted:	
Under 50 years	46
50-60 years	50
60-70 years	66
Over 70 years	163
Total	325
Patients Admitted From:	
Home	137
Local General Hospitals	134
Nursing Homes	12
County Infirmary Hospitals	13
County Home	6
Osteopathic Hospital	10
Saginaw County Hospital	10
Other	3
Total	325
Condition on Admission:	
Unconscious	4
Critical	61
Bedfast	154
Semi-ambulant	63
Ambulant	43
Total	325
Rehabilitation Potential on Admission:	
Yes	145
No	71
Doubtful	109
Total	325
Patients Discharged:	
Improved	178
Unimproved	16
Unchanged	1
Total	195
Length of Hospital Stay—Discharged Patients	
Less than 10 days	12
10-30 days	16
30 days and over	167
Total	195
Patients Discharged to:	
County Home	17
Nursing Home	23
Home	108
Infirmary Hospital	23
General Hospital	3
Saginaw County Hospital	3
Other	18
Total	195
(Average length of stay of discharged patients: 165 days)	
Patients Expired:	
Length of Hospitalization of Expired Patients:	
Less than 10 days	19
10-30 days	17
30 days and over	43
Total	79
(Postmortem Examinations: 46 cases or 58 per cent)	

The most satisfying observation is that 55 per cent of those discharged returned home and less than 3 per cent were transferred to general hospitals. The fact that 41 per cent were transferred to nursing homes and similar related institutions is indicative, of course, that this large group either has not a satisfactory home situation or failed to show any rehabilitation potential. Also the fact that 24 per cent of all admitted patients expired is indicative of the severity of illness among patients admitted. These facts are also indicative of the importance of early diagnosis and treatment.

In analyzing the group of 219 patients who were admitted unconscious, critical or bedfast, 61 patients returned home, 4 transferred to hospitals, 49 transferred to nursing homes, infirmary hospitals, or related institutions, 72 expired and 29 are still hospitalized.

Of the 106 semi-ambulant or ambulant patients, 58 returned home, 3 were transferred to hospitals, 25 were sent to nursing homes or related institutions, 13 still hospitalized and 7 expired.

In this report several points deserve note:

1. The County Hospital Rehabilitation Center and Chronic Disease Unit has been established to offer rehabilitation service for those patients who might be benefited from it There is general agreement that it is very difficult to determine, prior to hospitalization, the degree of rehabilitation potential possessed by patients. Those who can benefit from rehabilitation are given an opportunity for hospitalization for evaluation in the Rehabilitation Center.

2. Even though a large group of bedfast and

critical patients may not have rehabilitation potential, this indigent group, in our opinion, does not belong in a nursing home or medical-care facility because these patients need intensive medical and nursing care and hospital services which are not usually available to them in less complete medical facilities. In our opinion, these patients belong in a general hospital or a chronic disease hospital.

Because a large number of patients return home, we are making every effort to adjust the home situation, both physical environment and family attitudes, to the patients' needs. With this purpose in mind, the Home Nursing Coordinator in the Rehabilitation Center assists the families of the patients in many ways, some of which are as follows: (a) Helps to plan necessary changes and adaptations in the home to facilitate the patient's care on his return home. (b) To train the family in the fundamental principles of bed-side nursing, physical and occupational therapy as needed by the patient at home. This training program is provided in the Chronic Disease Unit. (c) Prepare the family psychologically to accept the patient and care for him at home. (d) Arrange for home medical supervision by the family physician. (e) Arrange for periodic recheck of discharged patients in the Rehabilitation Center when approved by the family physician.

Special Needs of the Program

Over 20,000 laboratory tests were made for Chronic Disease patients and 2500 x-rays were taken in the last twenty months.

In analyzing the clinical findings of 119 patients admitted in the year 1960, a very large number of co-existing conditions were found and many of them *per se* justified hospitalization. Many of these ailments have not been known by the patient or the physician prior to their hospitalization. The fact that many patients have a number of co-existing ailments reflects on the necessity of having laboratory, electrocardiogram, x-ray and dietetic services in institutions caring for long-term patients. This, of course, is in addition to the other services which normally would be available in the Rehabilitation Center.

Quo Vadis?

Obviously, the field is so new that there will be many problems and many reasons for slow progress. Some of these are governmental indecision, conflicting ideology, lack of professional enthusiasm for the program coupled with community apathy which will take many years to overcome. No longer, however, can the citizens and the profession maintain a "*status quo*" or "Horse-and-buggy" psychology toward the problem because present-day medical care of the aged should be in unison with present-day knowledge in the field of geriatrics.

Statements made by Dr. Freddy Homburger in connection with the debilitated hospitalized, elderly patients are worth repeating time and again.

> "The worst sin, which is committed every day in many nursing homes and hospitals, is to consider some of the extremely debilitated individuals as purely 'terminal care' problems or subjects for 'custodial' care. A few years ago, these were perfectly justifiable terms. The majority of such patients died after a few days of 'terminal' care and those who survived miraculously, remained hospitalized custodial cases for the rest of their lives.
>
> "Those who oppose this professional skepticism and advocate an aggressive therapeutic attitude toward the chronically ill and aged are able to accomplish much with the means at hand. They can rehabilitate many who have been given up as incurable and palliate the discomforts of those who cannot be cured. In the course of their work, they can uncover many areas for new researches that need to be conducted."

While in Michigan progress is being made, greater impetus to the program may be made from realization that there should not be any fear of competition with general hospitals because the hospitals for long-term patients have limited goals. The patients in need of surgical service or other services which are not available in institutions for long-term patients are transferred to a general hospital. The patients who do not have rehabilitation potential, or who do not need intensive medical care, should be cared for either at home or in nursing homes or in a medical-care facility.

The grave concern of all of us is how to meet the growing demands for hospitalization of long-term patients. Without doubt, a prerequisite for this is "the right bed, for the right patient, at the right time." Acceptance of this premise by the welfare departments, which hold the "purse strings" for medical care of indigents, is a goal often very difficult to achieve because of lack of medical leadership within the great majority of welfare department organizations.

How Can These Goals Be Reached?

Obviously we must have the doctors' cooperation, but the medical leadership from within an institution for long-term patients has a major responsibility to stimulate professional interest in the problems of geriatrics and rehabilitation. Every institution for long-term patients should promote conferences on

aging with speakers of national prominence to discuss with the doctors the challenge, problems and horizons in the field of rehabilitation for the aged. To achieve the goal of securing the doctors' cooperation, the hospitals for chronic disease patients should encourage the family physicians to take personal charge of their elderly patients. The medical leadership from within the chronic disease hospital should provide the private physicians with certain information regarding their patients' progress when these patients are temporarily cared for by hospital staff physicians. In Saginaw County Hospital, if the private physician does not take charge of the patient, a progress report is sent to the physician every six weeks.

Another method of maintaining the interest of the physicians in the problem of geriatrics is reviewing the individual patient's progress through visual demonstrations. We have attempted to do the following:

We take short moving pictures of every patient admitted to the Chronic Disease Unit. We repeat this procedure every six weeks or so, splice the films together and then show the film on the patient's progress to the physicians' group, or to the individual physician. These films take seven to eight minutes to run and give a chronological review of the patient's progress. We believe this method of visual reporting has been most helpful in developing professional interest among our physicians.

Summary

1. The proper medical care of long-term patients offers promise of return to normal living or self-care to many people. In our series 55 per cent of those discharged went home.

2. Every community and every professional group has a challenge to provide adequate facilities in the community for intensive care and a rehabilitation program for the aged not only in a hospital but also at home.

3. The cooperation of the physicians is our insurance for future progress in the development of a dynamic rehabilitation program in a chronic disease hospital and follow-up program at home.

4. To achieve the goal of "the right bed, for the right patient, at the right time," a screening system should be established for long-term patients. On the basis of our experience, any patients before being transferred to a nursing home or medical-care facility should be hospitalized in a general hospital or chronic disease hospital for the purpose of diagnosis, treatment, evaluation and determination of rehabilitation potential. Those patients who do not need intensive medical care could be transferred to a medical-care facility, a nursing home or a similar related institution. Those who show rehabilitation potential should have access to a rehabilitation program in a hospital that offers this type of service.

Limitation of space prevents a discussion on: (a) The importance of organized community efforts to the program; (b) Disability prevention through early diagnosis and treatment; (c) Role of the family in developing the patient's attitude; (d) Indispensability of the family physician and health departments in this program.

Finally, and in gratitude, we wish to report that the success of Saginaw County Hospital's program has been made possible through the fine cooperation of our physicians.

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Process of Aging

The greatest obstacle today to effective medical education in the field of geriatrics is "the lack of a substantial body of scientific information which defines and describes the process of aging."

"Senility . . . the difference between chronologic and biologic age . . . changes in bone and muscle tissue . . . and the onset of malignant disease are typical problems of aging which are now only partially understood," the dean said.

"If medical education is to meet the needs of geriatric medicine for the future, it must be in terms of a more effective understanding of the basis of the problems."—WILLIAM N. HUBBARD, M.D., Dean, University of Michigan Medical School.

The Aging Person in the Labor Force

Current Research Implications for Medical Care Financing

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A SENSE OF GREAT CONCERN is raised in the minds of many persons on hearing the oft-quoted statement that persons 65 years of age and over make up a smaller and smaller part of the United States labor force. Testimony before the McNamara Senate Subcommittee on Problems of the Aged and the Aging has stated that "about 11 million people at the present time aged 65 and over are dependent upon income or support from sources other than employment . . . (another) point, which is significant, is that the employment participation of men is declining. This, of course, is a very grave factor.[1,2]" The immediate question that most physicians, hospital administrators and voluntary health insurance plan officers have is "What does this mean to my community?"

The meaning of the decline in participation of the aged in the labor force may be highlighted by more intensive examination of the population and labor force data of the economy. The aged person in or out of the labor force does not stand isolated; social, economic and psychological forces must be considered.

Growth of Number of Aged

With advances in public health and medicine, the population aged sixty-five and over has increased approximately to 15.7 million in 1960.[3] Other sections of the population have also been increasing so that, while there has been a growth in numbers as a percentage of the total population, the portion of the aged in our economy has been leveling off.

As Mr. Ray Brown, Administrator of The Universsity of Chicago Hospitals, recently stated, "The experts say there will be 22 million people at aged 65 and over by 1975, compared with less than 14.5 million in 1956; an increase of 7.5 million or 52 per cent. This compares with the . . . increase in the total population of 29 per cent in the same period.[4]" The aged population, however, currently is 15.7 million out of a population of 180 million. With a relatively small base, any significant rise in numbers will cause a large percentage increase. The increasing growth of other age groups, however, has led to the estimate that the aged in the population will have increased only 1 percentage point from 1955 to 1975.

The United States is, therefore, more than halfway through its immediate population growth as far as the aged are concerned with approximately 16 million persons out of a potential 22 million aged persons by 1975. The greatest growth of the population will be among those between aged 10 and 19, the high school and college age group. This group does not utilize the hospital or physician a great deal and does not normally present a payment problem.

Years After Age Sixty-Five

Life expectancy has increased in the 20th century. In 1900, the life expectancy for white males was 48.2 years; by 1957 it was to 67.1 years. The latter figure is for a person who is born in 1957.[5] He is, however, not going to live 67.1 years between 1957 and 1975. Many aged persons now alive have lower life expectancies than those for children now being born. The greatest improvement in life expectancy has been among females. In 1900, the life expectancy of a white female was 51.1 years; for a non-white female it was only 35 years. By 1957 the life expectancy for a non-white female was 65.2 years and for a white female, 73.5 years.[5] Once the 65th birthday has passed, life expectancy is not changed greatly for the majority. In 1900 for a white male, life beyond 65 years of age was 11.5 years, by 1957 it was 12.7 years, or an increase of only a little over one year; for a white female, it went from 12.2 years to 15.4 years. The significant increases in life expectancy at age 65 have been in the non-white population.[5] More people are living to be 65, but once past this "magic dividing line" their life expectancy has not increased greatly.

Expansion in Work Life and in Retirement

In our concentration on the problems of the aged and retirement, the expansion of the American economy has sometimes been overlooked. Between 1929 and 1960, the gross national product in the United States rose from $104.4 billion to $501.3 billion, or an increase of nearly fourfold.[6] And the population increased from 76,094,000 in 1900 to 180,793,000, or less than a tripling of the population by 1960.[7]

In order to accomplish this tremendous growth in production, there was an increase not only in capital accumulation, but also in the working life of the individual. Fifty years ago there was very little difference between total life span and working life among men. Today, with a higher life expectancy of men and earlier labor force exit, the years spent in retirement have lengthened, but not as much as the years participating in the labor force. In 1900 the work-life expectancy for males was 32.1 years; by 1955 it was 42 years, an increase of practically 10 years. For females in 1900, the work life expectancy was 6.3 years; by 1955 it was 18.2 years.[8] Under 1900 conditions, a man of 20 had a life expectancy of 42.2 years, and a work life expectancy of 39.4 years. This meant a period of retirement of 2.8 years. By 1955 the years in retirement had increased to 6.5 years. In 1900, males entered the labor force earlier and left it later.[8] Under 1955 conditions, men entered the labor force much later having completed at least a high school education on the average. With this increase of practically 10 years of work life, he is able, on the average, to increase his amount of liquid and fixed assets available to him in retirement, not withstanding the increase in taxes.[9]

Decrease in Number of Non-Productive Workers

The Department of Labor estimates that for every 100 persons in the population in 1900 there were 36.4 workers; by 1940 this had been raised to 40.5 workers. By 1950 it had declined slightly to 39.9, but by 1956 it had been raised to 41.5 workers. It is estimated that by 1965 it may rise to 41.8.[8] Despite the growth in the number of the dependent groups, especially the very young and the old, during the present decades, the ratio of workers to the total population has risen, not fallen, and is expected to remain at a level of about 42 per cent to 1965. Part of the explanation is the huge increase in labor force participation by females. Today, despite the marked delay in entry into the working force and earlier exit, men put in more years of work than did their counterparts 50 years ago. In 1957, 53 per cent of all men aged 65-69 were still in the labor force, though only 28 per cent of those aged 70 and over remained in the labor force.[2] Longer life has enabled increased education, working and retirement time.

Increase in Number of Aged Who Are Non-Productive

For the last 50 years, there has been a steady decline in the percentage of non-workers in relationship to the productive workers in the labor force. In 1900, however, persons aged 65 years of age and over made up only 4 per cent of the non-workers, but by 1950 the aged made up 10 per cent of the non-workers.[10] In 1957, with a total population of over 171 million and the labor force estimated at 70 million, the ratio of non-workers among the aged increased to 11.5 per cent of this dependent group.[11]

This increase in the non-productive aged has been brought about by a series of demographic and social forces:

Greater Number of Persons in Older Age Group.— In our concern with the aged we have attempted to place all of the men and women 65 years of age and over into a single homogeneous group. There has been a tendency to overlook that there comes a point in a person's work life when he is no longer able to participate within the labor force for social or productive reasons. With the advances brought by medical science more and more people have been able to live over 70 and 75 years. There still comes a point when participation in the labor force does not have much attraction, and a decline in labor force participation by men and women in their seventy's and eighty's can be expected.

With the increase in longevity of women, the number who have never worked outside the home has increased also, and these women account for part of the decline in labor force participation. In March 1951, the Bureau of the Census conducted a sample study on persons 65 years of age and older who had any work experience during the last 10 years. "Of the 7 million people in this group, 5.3 million (mainly women) reported they had not been gainfully employed even a single day during the past 10 years." This, in a war period during which the demand for labor was extremely high, indicates that not even the pressures of World War II could induce them to accept jobs or employers to provide them with jobs.[12] Since women have a greater life expectancy than men

in the years after age 70, the statistical increase in the non-productive labor force for the entire group over age 65 is to be expected.

Compulsory Retirement Programs of Private and Public Industry have caused many persons to leave the labor market.[13] Part of the labor force exit may be due to lack of skills of these older people or, under the impact of automation, their past training may be obsolete. Movement of industry from settled areas in the North to suburban areas of large cities or to the South and West also have caused elderly persons to accept retirement, since they are unwilling to give up the ties of twenty to thirty years in a community in order to stay with the firm a few more years.[14] Although studies have shown that older workers are as productive as younger workers in many cases, employers are reluctant to hire older employees because of fears of potential costs of workmen's compensation, unemployment compensation or pensions.[15]

Farmers.—Many old people live in farm or rural non-farm areas. With the introduction of the soil bank plan under the United States Department of Agriculture, it has been to the advantage of many old farmers to "put their farms in the soil bank" and live off the proceeds.[16] Technically, they are out of the labor market; in reality, some are receiving as much income as they would have, if they continued farming.

Health Reasons.—Every survey shows that a large number of the aged leave the labor force for health reasons.[17] What has not been carefully analyzed is the low proportion of those retired persons answering the survey who leave industry due to compulsory retirement programs. On answering interviews, the retirees say that they have been let out because of health reasons.[17] Yet, if compulsory retirement is so widespread in American industry, we would expect much higher compulsory retirement reasons for their exit from the labor force. One may suspect that the health reasons may not be as important as obsolescence of skills.

No matter what the reasons, there has been an increase in the number of persons aged 65 years and over who are not receiving their income directly from the labor force participation. For the future these people may indicate the following to the purveyors of medical care:

More people may be living to 70 and 80 years of life at the present time. Many of these people are receiving Old Age Assistance (OAA). In Illinois, the average age of a person on OAA was 76 in 1953. Many of those in the over-70 age group are given support by public aid. In estimates made by the United States Department of Health, Education and Welfare this group will still remain by 1970.[18] Even with the growth in the Old Age Survivors Insurance (OASI) mechanism it is estimated that approximately 2.2 million persons age 65 and over or 11.3 per cent of the total aged will still be receiving OAA.[18] If the local public aid officials do not pay a fair share of the medical and hospital costs in providing care to the indigent, including the aged indigent, these persons may be a definite burden on the hospital, physician and the community.

Part of this increase in the nonproductive workers is a result of the creation of the industrial pension system with the flurry of collective bargaining agreements following the Inland Steel decision of 1948. Many large firms have instituted a pension system for the entire labor force since that time. By 1957, apart from the OASI program, 47 per cent of all non-agricultural workers had pension programs in the firms for which they worked against 34 per cent in 1945.[19] 1.3 million workers were receiving benefits from the private retirement plans in 1957. Additional pensions are being paid by the federal and local government pension programs. One group is receiving benefits under the Railroad Retirement System. Some retirees receive their pension check, social security check, and also a package of medical, hospital and surgical benefits provided to them in retirement. This group of recent retirees and their wives do not generally present an acute utilization or payment problem to the hospital.

Comment

The raw data that are being used on the labor force participation of the aged may not present the entire picture. Income from labor force participation is only one source of support for these persons. They also have their assets and resources to be called upon when it is necessary to provide for needed goods and services, including medical services. As an example, those 65 years of age and over receive $451 million annually in income from annuities.[19] In addition, when considering payment for medical care services, there may be an additional resource to pro-

vide payment for needed services in a "crisis." Recent research has shown that there are large numbers of aged persons living either with their families or in close proximity to their families.[20,21,22] For these aged persons it is the "extended" family that may be able to help them pay for the acute hospitalization or medical care bills.

Decline in labor force participation by the aged historically has been the sign of a rich or powerful nation. It has been found that nations with the highest participation of aged persons in their labor force are the poorest nations, Spain and Greece are examples. Nations with the low participation are the industrial countries such as the United States, the United Kingdom and Belgium. By itself, the decline in participation in the work force by men normally is a sign of a healthy economy able to support this non-productive element.

Although the burden of support for older persons and for their families in the next 25 years will fall upon an increasingly smaller proportion of the working population between the ages of 21 and 44, the increased use of capital and resulting higher productivity per man hour may lessen the burden of the non-productive young and old sections of the population on the economy In addition, it is hoped that the decrease in participation of the aged male and his replacement in the labor force by the better educated younger worker, the overall productivity of the labor force will not decline.[23,24]

There are, however, some unanswered implications for the future that may affect the voluntary health insurance field more than the physicians:

1. With the increase of those in the age 70-75 bracket, the increase in utilization of hospitals will be accentuated.[25] It is among this group that relatively heavy users of hospital services are found.

2. The large number of widows will have an effect on hospital utilization. Research in the United States and England seems to show that the single, widowed and divorced person makes more use of the hospital than those who are living with the spouse.[26,27]

3. It is expected that, based on experience of the late 1950's, those that are out of the labor force will make greater use of the hospital. For those in retirement and out of the labor force a greater use of the hospital is to be expected.

4. Research indicates that as more beds are available the more use there will be made of them. As we build more beds to meet the needs of our growing population in the next decade, it is expected that more and more of the aged people will make use of them. Research data from New York State, Saskatchewan, and Virginia show a per capita rise in utilization of hospitals as more beds are built. The increase in the number of the beds will lead to an increase in utilization by the entire population particularly by the aged.[28,29,30]

5. The growth in voluntary health insurance: The Department of Health, Education and Welfare states that, at the present rate of growth, "about 70 per cent of the aged beneficiary group will have some form of health insurance by 1965."[31] This estimate may be on the low side due to the current new enrollments in Blue Cross Plans and voluntary health insurance mechanisms. All available data show that those with voluntary health insurance use the hospital more than those without it. In addition, as we improve the plans for the aged by providing larger and better benefits, their hospital utilization will increase. Research in New York indicates that the better the plan of voluntary health insurance for the aged, the higher the utilization.[25]

6. The younger physician: With the decline in the number of older physicians trained before World War II in the next ten years and the increase in the number of younger physicians trained since the war increasing, hospital utilization may increase. Some research indicates that younger physicians tend to hospitalize their patients to a greater extent than those trained before the war.[30]

With these social forces operating and with voluntary health insurance available to pay for the hospitalization of the aged, in many cases, it may be expected that hospital utilization for the aged will rise and therefore the cost of providing this voluntary health insurance either on an experience-rated or community-ruled basis will also increase.

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Statistics on Aging

". . . Persons aged 65 and over constitute a substantial segment of the United States population, and their relative number is increasing.

The number of people aged 65 and over has more than quadrupled in the last 50 years, from 4.0 million in 1910 to 16.6 million in 1960.

In 1960, persons aged 65 and over constituted more than 9 per cent of the population compared with 4 per cent in that age group in 1910.

The Census Bureau estimates that by 1980 persons 65 or over will total 24.5 million, about 9 per cent of the total population, or approximately the current level.

Life expectancy at birth now approaches 70 years as compared to a life expectancy of 47 years in 1900. A 65-year-old person can now expect to live 14 more years."—"Areawide Planning for Hospitals and Related Health Facilities." Report from U. S. Public Health Service.

Medical Assistance for the Aged Act

AN ACT to provide medical assistance for the aged; to prescribe the terms and conditions for such medical assistance; to prescribe the powers and duties of the state department of social welfare and certain other state officers and agencies; to authorize the transfer and expenditure of state funds; and to prescribe penalties for the violation of this act.

The People of the State of Michigan enact:

Sec. 1. This act shall be known and may be cited as the "medical assistance for the aged act."

Sec. 2. As used in this act:

(a) "State department" means the state department of social welfare.

(b) "Commission" means the Michigan social welfare commission.

(c) "County bureau" means the county bureau of social aid.

(d) "Medical assistance for the aged" means medical and ancillary services as described and circumscribed in this act rendered persons eligible therefor.

(e) "Annual income" means income received during the 12 months preceding or anticipated during the 12 months following application for medical assistance under this act.

(f) "Medical institution" means a hospital certified by the state health commissioner or a county medical care facility.

Sec. 3. The state department shall establish a program for medical assistance for the aged under Title 1 of the federal social security act, as amended by Public Law No. 778 of the 86th Congress. Medical assistance for the aged shall be granted to any resident of this state 65 years of age or older who meets all of the following conditions:

(a) He has made application therefor in the manner required by the state department.

(b) He is not receiving old age assistance.

(c) His need for the type of medical care available under this act for which application has been made has been professionally established and no payment for it is available through the legal obligation of a contractor, public or private, to pay or provide for such care without regard to the income or resources of the patient. No payment shall be made under this act for any hospital service for any injury, disease or disability for which the patient is entitled to hospitalization or the cost thereof under the workmen's compensation law; except that payment may be made if an appropriate application for hospitalization or the cost thereof has been made under the workmen's compensation law, entitlement thereto has not been finally determined, and an arrangement satisfactory to the state department has been made for reimbursement if the claim under the workmen's compensation law is finally sustained.

(d) He, if unmarried, or not living with the spouse, has an annual income from all sources of not more than $1,500.00. If he is married and living with the spouse, he may have an annual income, including the annual income of the spouse, of not more than $2,500.00. Included in income shall be the amount of a contribution which a son, daughter or estranged spouse should be making to the applicant according to the standards of the state department, or pursuant to a court determination, if there is such a determination, except that the contribution shall not be included in income in respect to an application for hospitalization during the first 30 days of such hospitalization.

(e) He, if unmarried, has liquid or marketable assets of not more than $1,500.00 in value, or, if married, he and the spouse have liquid or marketable assets of not more than $2,000.00 in value. Excluded in making the determination of the value of liquid or marketable assets are the values of: (1) the homestead, (2) clothing and household effects, (3) cash surrender value of life insurance, and (4) not to exceed $1,000.00 of the fair market value of tangible personal property used in earning income.

(f) He has made no assignment or transfer of any real or personal property or income within 5 years immediately preceding the date of application for assistance under this act for the purpose of qualifying for medical assistance for the aged or for any form of assistance granted under the social welfare act, or for the purpose of increasing the amount of medical assistance for the aged or any form of assistance

This act, introduced by Senators Beadle and Ryan at the extra session of the State Legislature in 1960, was revised for presentation at the 1961 session of the State Legislature and became law this year.

granted under the social welfare act or for the purpose of precluding recovery.

(g) He is not a patient in any institution as a result of a diagnosis of tuberculosis or mental disease.

(h) He is not an inmate of a public institution except as a patient in a medical institution.

Sec. 4. Eligibility for medical assistance for the aged shall be determined by the county bureau in which the application was filed. When eligibility has been established, the county bureau shall notify the county social welfare board of the county in which the applicant resides and list the type of services under this act which are required. The county social welfare board shall make provision for the services as long as needed or until notified by the county bureau that eligibility no longer exists. Service shall not be resumed after discontinuance without a new notification from the county bureau. The state department shall pay the county social welfare board for services provided under this act, after approval of each invoice by the county bureau, not less than 90% of the amount thereof from moneys available in a special medical assistance for the aged subaccount hereby established as part of the medical assistance account created by section 11 of the social welfare act, as amended. The commission may reduce the services available under this act to the extent necessary to keep payments from the subaccount within the appropriation available. The state department may determine the propriety of all claims for services rendered under this act.

Sec. 5. The state department may file a claim for reimbursement from the estate of a deceased recipient of medical assistance for the aged for payments made during his lifetime but no claim shall be paid until after the death of a surviving spouse if there is one except a claim made in respect to improper payments of medical assistance. All claims under this section shall be fifth class claims.

Sec. 6. The powers and duties of the state department and the county departments of social welfare relating to the administration of federally subsidized programs under the social welfare act are hereby granted and imposed on these departments insofar as applicable to medical assistance for the aged. Such rules and regulations shall provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of this act. A hearing shall be provided any applicant or recipient of medical assistance under this act as provided in sections 9 and 37 of the social welfare act. The commission shall adopt all necessary rules and regulations for implementation of this act in accordance with Act No. 88 of the Public Acts of 1943, as amended, being sections 24.71 to 24.82 of the Compiled Laws of 1948, and subject to Act. No. 197 of the Public Acts of 1952, as amended, being sections 24.101 to 24.110 of the Compiled Laws of 1948.

Sec. 7. Persons eligible for medical assistance shall be entitled to the services enumerated in sections 8, 9 and 10 of this act. Such services shall be rendered upon certification by the attending licensed physician that a service is required for the medical treatment of an individual. The services of a medical institution shall be rendered only after referral by a licensed physician and certification by him that the services of the medical institution are required for the medical treatment of the individual, except that referral shall not be necessary in case of an emergency. Periodic recertification that medical treatment which extends over a period of time is required in accordance with regulations of the state department shall be a condition of continuing eligibility to receive medical assistance.

Sec. 8. Hospital services to which an eligible person is entitled, when furnished by a hospital certified by the state health commissioner or by a county medical facility approved by the department, shall not exceed those services furnished by the Michigan hospital service corporation under its comprehensive hospital care certificate in effect on September 1, 1960, and on file with the state commissioner of insurance, as determined by the state department. The period of inpatient hospital service shall be the minimum period necessary in this type of facility for the proper care and treatment of the individual.

Sec. 9. Physicians' services to which an eligible person is entitled shall not exceed those services furnished by the Michigan Medical Service under its M-75 Blue Shield plan in effect on September 1, 1960, and on file with the state commissioner of insurance, as determined by the state department.

Sec. 10. Effective July 1, 1961, home nursing service may be provided to the extent found necessary by the attending physician and the state department. Following hospitalization for acute illness, care in a state licensed nursing home may be provided for not to exceed 90 days in any 12 months' period.

Sec. 11. Any person who violates any provision of this act for which no penalty is provided is guilty of a misdemeanor. Whenever any person receiving medical assistance for the aged is found to have provided inaccurate information regarding his resources or income or those of his spouse, the amount of medical assistance for the aged granted during any month in which the person was ineligible may be recovered in an action at low. Failure to provide the state department with full and accurate information at time of application or promptly thereafter whenever changes occur in property or income shall constitute a fraud.

This act is ordered to take immediate effect.

County Welfare Directors

COUNTY	NAME AND ADDRESS	PHONE NUMBER
Alcona	Mrs. LaReign I. Johnson, Box 118, Court House, Harrisville	PArkview 4-5138
Alger	Miss Alice C. Tucker, Box 354, Court House, Munising	EVergreen 7-2253
Allegan	Mrs. Beatrice Guscinski, Court House, Allegan	ORchard 3-2143
Alpena	Mrs. Florence Brooks, Court House, Alpena	ELmwood 6-1570
Antrim	Mrs. Helen Smith, Court House, Bellaire	JEfferson 3-3366
Arenac	Miss Clara M. Stone, Court House, Standish	VIking 6-7511
Baraga	Mr. Kenneth J. LeBerge, Box 136, Court House, L'Anse	L'Anse 4-3987
Barry	Margery R. Dryer, Court House, Hastings	WIndsor 5-2274
Bay	Carl Anschutz, 812 N. Jefferson, Bay City	TWinbrook 5-5527
Benzie	Clayton McCombs, Court House, Beulah	TUrner 2-4311
Berrien	Wesley Bowerman, 305 Michigan, or Box 652, Benton Harbor	WAlnut 6-2138
Branch	Willmar Moore, Court House, Coldwater	BRoadway 8-5327
Calhoun	William Morgan, 203 Capitol Building, Box 240, Battle Creek	WOodward 2-5195
Cass	Mrs. Ruth Larson, Court House, Cassopolis	HIckory 5-2971
Charlevoix	Mrs. Doris Reynolds, Court House, Charlevoix	LIberty 7-2091
Cheboygan	Preston H. Davis, Court House, Cheboygan	MAdison 7-2211
Chippewa	Albert Bernabucci, 140 W. Spruce St., Salte Ste. Marie	MElrose 2-3377
Clare	Mrs. Leanore Hughes, Court House, Harrison	KEllogg 9-4171
Clinton	Mrs. Julia Jury, 111 E. Walker, St. Johns	CAnel 4-4869
Crawford	Mrs. Ruth Bidvia, Hendershot Building, Huron Street, Grayling	DIckens 8-8621
Delta	Lyle Plowman, State Office Building, Room 233, 305 Ludington, Escanaba	STate 6-5394
Dickinson	Sol Beaupariant, 805 Vulcan, Box 429, Iron Mountain	774-1484
Eaton	Mrs. Eva Ruperd, 117 W. Lawrence, Charlotte	543-0860
Emmet	Mrs. Ruth E. Chamberlain, 218 Park Avenue, Petoskey	DIamond 7-2471
Genesee	Edward J. Sieniki, 2413 Industrial, Flint 5	CEdar 9-3101
Gladwin	Mrs. Sylvia Richmond, Court House, Gladwin	GArden 6-9251
Gogebic	Walter E. Bennetts, 305 S. Sophie Street, Bessemer	2711
Grand Traverse	Firmin Ruenauver, Court House, Traverse City	WIndsor 7-6232
Gratiot	Mrs. Elizabeth Donahoe, Court House, Ithaca	5241
Hillsdale	James Gier, Court House, Hillsdale	HEmlock 7-2112
Houghton	Royce Koskinen, County Welfare Building, Box 630, 116 Quincy, Hancock	3390
Huron	Stanley J. Lerash, 180 E. Huron Avenue, Bad Axe	COngress 9-7201
Ingham	Daryl V. Minnis, 101 E. Willow, Lansing 6	IVanhoe 5-1751
Ionia	Mrs. Hazel Smith, Court House, Ionia	83
Iosco	Edward Burgeson, Box 401, Court House, Tawas City	FOrest 2-2231
Iron	Victor Sheput, 139 East First Street, Caspian	CO 5-9221
Isabella	Maynard Cole, Court House, Mt. Pleasant	SPring 5-3691
Jackson	Robert D. Woodard, 410 E. Ganson, Jackson	STate 4-9101
Kalamazoo	Paul Avery, 1010 Prairie, Kalamazoo	FIreside 2-9874
Kalkaska	Angeline Van Coillie, Court House, Kalkaska	ALpine 8-5522
Kent	Rupert Kettle, 1260 Butterworth S.W., Grand Rapids 2	451-2031
Keweenaw	Miss Elizabeth Bryant, Allouez Township Building, Box 352, Mohawk	617
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Lenawee	Harold F. Hough, 113 W. Front, Adrian	COlfax 5-8264
Livingston	Cecil Bohm, 304 E. Grand River, Howell	95
Luce	Alvin Covell, Johnson Building, Drawer 27, Newberry	251
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Mason	Mrs. Geneva Lindquest, Court House, Ludington	VIctor 3-8800
Mecosta	Mrs. Lela Freiberg, Court House, Big Rapids	796-5535
Menominee	Mrs. Bernice Paquette, Court House, Menominee	UNion 3-5612

COUNTY WELFARE DIRECTORS

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Montcalm	J. Howard de Spelder, 125 W. Main Street, Stanton	TErrace 1-5244
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Oceana	Clyde Lombard, Box 142, County Building, Hart	95
Ogemaw	John J. Nye, R. No. 3, State Road, West Branch	190
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Saginaw	Gwendolyn M. Lee, Court House Annex, Saginaw	PLeasant 2-5114
Sanilac	Harold E. Phelps, Court House, Sandusky	78
Schoolcraft	Miss Maria Tracy, Box 148, Court House, Manistique	78
Shiawassee	Ted Hicks, Pleasant View Hospital, Corunna	RIverview 3-3491
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St. Joseph	Milo Miller, 327 N. Dean Street, Box 156, Centerville	HObart 7-8425
Tuscola	Irl L. Baguley, Court House, Caro	OSborne 3-3414
Van Buren	Emmett J. Thomas, County Infirmary Building, Hartford	2713
Washtenaw	Alfred Brose, County Building, Room 132, Ann Arbor	NOrmandy 3-7511
Wayne	Walter J. Dunne, 1025 E. Forest, Detroit 7	TEmple 3-4430
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Allergic Anaphylaxis

"Probably the first allergic disease described is that of insect allergy," says Peter P. Barlow, M.D., of The University of Michigan Medical Center.

"In 2641 B.C., King Menes of Egypt met his death following a wasp or hornet sting. . . . Over the years, there have been occasional isolated reports of death due to insect stings."

Some sudden deaths reported as due to heart failure or heat prostration may really be cases of allergic reactions to stings, Dr. Barlow says, adding that everyone reacts to the stings of bees and wasps—there is pain, redness, probably swelling, and it may last one or two days.

This is a normal reaction to the insect's venom, while an allergic reaction to an insect sting "is either a very severe reaction at the site of the sting such as swelling, or other reaction such as asthma, hay fever, hives, or allergic shock."

Dr. Barlow explains that according to the principles of immunology, we build up an immunity to certain diseases either by vaccination or by actually having the disease. Our bodies form protective antibodies in the blood when we are first exposed to a harmful agent. Occasionally, when the antibody combines with the offending agent, allergic shock, called "anaphylaxis," may occur due to the liberation of certain chemicals.

Self-Help Devices in Arthritis

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IN THE FIELD of chronic illness, the chief disabler is arthritis. Disregarding the immediate classification of the type of skeletal involvement, when definitive care has been exhausted (or is still being maintained), physical medicine and rehabilitation is the only discipline applicable in management of the arthritic patient. By the judicious use of physical and occupational therapy procedures, it becomes possible for the patient to meet the normal demands of daily living. As improvement in efficiency of function results, the program can be enlarged to become "dynamic and total, designed to meet the physical, emotional, social and vocational needs" of the chronically disabled. Therefore, the purpose of this discussion is to elaborate one segment of such a program, namely, the utilization of adaptive equipment (usually termed self-care devices) in promoting needed functions in the activities of daily living.

Retraining must be in the essential activities of self-insufficiency: personal hygiene, dressing, eating, travel which consists of ambulation and elevation, general activities about the home, shopping and business areas. The adaptive equipment and training in usage takes cognizance of upper and lower extremity joint limitation and weaknesses, resulting in a maximal improvement of function.

The major pathologic process is that of interference with joint motion. In the upper extremities, loss of reach and grasp must be lessened by the use of adequate devices and rehabilitation techniques. Limitations of the shoulders interfere with dressing and eating; in the elbows, flexion deformities with limited pronation and supination prevents rotation of objects; stiffness of the fingers reduces dexterity and prehensile grasp. When the thumb and the two adjacent fingers are stiff, self-care in buttoning, grasping, writing, typing are diminished in proficiency. Ulnar deviation deformity prevents hand usage in general activities at home and at employment. Frequently, the non-dominant hand must be retrained with the involved hand and its adaptive equipment then becomes the assistive limb. Where the spine becomes "rhizomylique," the ramrod posture interferes with positional change, getting in and out of bed and chairs or transference to a horizontal or vertical position. Stiffness at the hips results in essentially the same limitations. Stiffness of the knees and ankles interferes with ambulation and stair climbing (elevation). Finally, where extensive involvement is present, as in rheumatoid arthritis, transference to and from a wheelchair, to a bed or toilet seat, car seat and the like then requires special wheelchairs, elevated toilet seat and the like. Braces, crutches, canes, plaster and plastic supports are important, but will not be elaborated upon in this paper.

With reference to physico-pathologic factors, functional interference in arthritis is important. Pain, fatigue, increasing trauma to weight bearing joints must be lessened. Cardiac and pulmonary studies have shown a 20 per cent lessening in cardiac output when an arthritic can ambulate, than when he requires crutches. Lack of motivation and dependency on the family is lessened, resulting in less psychological trauma to self and members of the milieu. Efficiency in performance improves, both as a homemaker and as a breadwinner.

Only a few aspects can be discussed relative to a handicapped arthritic patient in the application of self-help devices; the following discussion is illustrative.

A. *Stiffness of Spine and Hips.*—This interferes with dressing functions at the level below the umbilicus.

1. *Dressing Activities*
 (a) Pulling on shorts in a lying, sitting or standing position: tape loops are sewed into the waistband; two dowels with cup hooks are inserted, helping to pull on the garment.
 (b) Strips are tied to belt loops or suspenders are preattached: used for pulling up trousers.
 (c) Zipper fly front closing to which is attached a small ring for easier grasp.
 (d) Stocking put-on devices: long tapes with corset garters at top of stocking, loops on stockings with dowels with hooks, commercial devices such as "stocking put-on or stocking aid."

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(e) Shoe horns of the long-handled variety to permit easier insertion of feet.
(f) Tying shoelaces when unable to bend can be obviated by permanently tied elastic laces or a zipper with a metal ring in the guide.

2. *Toilet Transfer.*—In toilet transfer necessitated by hip and knee involvement, the ingenuity of the patient and family must be utilized as follows:
(a) Ordinary elevation of toilet seat.
(b) Raising of toilet on a wooden base.
(c) Wall hung toilet.
(d) Soft toilet seats padded with sponge rubber, producing the necessary elevation.
(e) Glider commode chair which slides over toilet seat.
(f) Arm rests to permit getting on and off toilet (either a grab bar or one supported on toilet bowl or floor.)

3. *Bed Transfer.*—This is difficult for the hip and knee as well as the spondylotic. The general principle involved is that the higher the bed, the better is the fulcrum to permit to-and-from bed movements.
(a) Wooden blocks are simple, cheap and permit adequate bed elevation.
(b) In wheelchair-confined arthritics, it is best to adjust the bed level to that of the wheelchair. A simple slide band of plywood can be used to bridge the gap of chair and bed, using detachable arms on the chair.
(c) Motorized bed unit permits elevation and lowering of head and foot of bed, raises to a sitting position and also permits the transference to wheelchair.
(d) Overhead trapeze for the ankylosed spine and hips or for the stiff knee permits self-transference when the upper extremities are functional.
(e) Portable lift can always be used when patient is in a fixed position of ankylosis.

4. *Tub Transfer.*—If a stall shower is available, it is generally far too small to permit maneuvering.
(a) Rail placement is important and should be determined by body mechanics. Grab bars properly placed permit ingress and egress from a tub.
(b) Slide board of plywood frequently permits easy access to own tub.
(c) When unable to step in and out, use a bench or a straight chair.
(d) If unable to lower self in tub, sit on a bench in tub and use shower hose.
(e) Commercial devices are available to help in tub transference: lifeguard rail, stepping stools, bath chair and portable lifts can be used.

B. *Impairment of Upper Extremities (with limited shoulder, elbow, or hand functions).*—Awareness of the general principles involved will lessen the need for complicated and expensive devices. It is wise to avoid clothing which fastens in the back; attempt to have two-piece garments, sleeves should be full except for arthritics who require axillary crutches; proper type of garment fasteners (these have been mentioned in the lower extremities.)

1. *Dressing Requires Simplified Clothing.* Zippers should have attached metal rings, use buttonhooks where there is loss of finger dexterity; hooked instead of tying aprons; loose sport shirt with short sleeves; dowel with attached closet hook pushes garment off of stiff shoulder; cuffs which are pre-buttoned or have elasticized thread as guides. Special clothing is manufactured for the women. coat dresses, tailored slacks, cotton belt with two detachable pockets with an attached Velcro closure (this is a two-strip nylon tape with a one-loop hook); tape with a Velcro closure.

2. *Bathing Aids* to compensate for restriction of motion in use of washcloths, brushes, and combs.
(a) Washcloths can be attached to a handle; a flexible rubber paddle attached to a jointed wooden shaft angled for approach to face permits easy function.
(b) A plastic sponge rubber bath brush gives increased reach, and contains a soap pocket.
(c) Nailbrush over palmar surface of hand with an attached grip or holder where one hand functions; or it may be attached to the wall by suction cups at the washstand.
(d) A bar of soap in a mesh bag worn about the neck permits personal hygiene.

3. *Eating Aids* are determined by the hand or reach problem.
(a) Long-handled spoons or forks—fifteen or more inches as required to compensate for loss of reach.
(b) Enlargement of the handle of the implement for loss of grasp.
(c) Rocker knives for cutting food are useful where incapacity is in dominant hand.
(d) Simple plate guards to keep food from falling off plates.
(e) Suction cups are useful for stabilizing dishes on the eating tray or table.

4. *Drinking Problems* may be simplified in a fashion to compensate for grasping and tilting; light-weight tumblers clip on involved hand to hold glass, plastic straw with metal clip to glass. When patient is bed-confined, there are commercial devices to prevent spillage in drinking utensils: "Kant Spill," "Wonderflo Cup," plastic container with tight-fitting cover and hole for plastic straw.

5. *Telephoning Devices* are available and are for reaching, grasping, and maintaining hold on handset. Dialing devices such as pencils, dialer, utensil holder, cuff around palm with dialer inserted into dowel can be used.

C. *Severe Involvement with Wheelchairs.*—It is important to remember some simple principles dependent on the handicap limitation. A wheelchair must be prescribed by the physician: adult or junior type, removable desk-arms, swing-away foot rests, hand brakes, size of wheels and casters, and even a pleasing color. There are infinite self-devices which can be bought, homemade and those fashioned by the patient. Many details of such equipment may be obtained from the Self-Help Device Office at the Institute of Physical Medicine and Rehabilitation in New York, a project supported by the Arthritis and Rheumatism Foundation.

In conclusion, the principles of physical medicine and rehabilitation utilizing self-help devices can make it possible for the handicapped arthritic patient to learn to live his life "in independence and with dignity. Some could return to work. The benefits of rehabilitation would not only extend to the disabled person alone, but to their families and to society as a whole."

Diagnosis and Treatment of Gout

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GOUT is a disease of uric acid metabolism. Gout has two forms: The first form is primary gout, which is an inherited disorder. The second form is secondary gout where the disturbance in uric acid metabolism is secondary to some other disease such as polycythemia vera, hemolytic anemia, lymphomas, leukemia, glomerulonephritis, or pernicious anemia treated with liver therapy. Although the mechanism for the abnormality in the purine metabolism is different in the secondary form, the clinical manifestations including acute and chronic arthritis, tophi or renal calculi are similar, as is the treatment. This paper, therefore, will restrict itself to the discussion of primary gout.

Gout is an important disease for the following four reasons:

1. It is a common disease. Many figures are available as to the incidence of gout, but an approximation of 1 per cent of the population would not be too inaccurate.

2. It is a chronic disease with a long duration of progressive illness. It will therefore be more common in an aging population. Among 300 residents in a home for the aged, the author found three definite cases of unsuspected gout and two other cases of probable gout.

3. The arthritic and other manifestations are painful, disabling, and even potentially lethal.

4. There is effective treatment for all phases of the disease and effective prophylaxis for all of the complications of the disease. The complications include renal calculi, tophaceous deposits in the bones, joints, bursae, tendons, blood vessels, mitral valve and cardiac muscle, nephrosclerosis with deposits in the parenchyma of the kidney, hypertension and atherosclerosis.

A recent study by Mustard and associates[1] showed a more active clotting mechanism in patients with gout with increased platelet counts and other abnormalities of clotting. This may explain the clinical impression of increased thrombotic vascular complications in gouty patients.

Pathogenesis of Gout

The pathogenesis of gout is unknown. A family incidence of about 15 per cent shows some hereditary mechanism. Talbott[2] found that 25 per cent of 13.6 non-gouty relatives of patients with gout had hyperuricemia. Pedigree studies suggest a single dominant factor of incomplete but high penetrance. However, Hauge and Harvald[3] believe that accumulate gene action may be the cause.

Using radioactive isotopes, much has been learned about uric acid metabolism. It has been shown that dietary purines contribute only small amounts of uric acid to the miscible pool as the body forms uric acid from carbon dioxide, glycine, and ammonia. Wyngaarden[4] showed that there is an overproduction of uric acid from glycine in some gouty patients, and this is often several times greater than the 1200 mg. of miscible pool in normal subjects.[5]

There also appears to be some deficiency in the secretion of uric acid by the kidneys in some gouty patients.[6] Uric acid is filtered through the glomeruli, reabsorbed but also actively secreted by the tubules.[7]

Diagnosis

It is commonly taught that the diagnosis of gout is a simple one. All that one needs to do is to think of it and then one will make the diagnosis. This is an oversimplification of the problem. Although about 50 per cent of the cases of gout will begin clinically with podagra and be simple to diagnose, the other 50 per cent may be very difficult to diagnose. The history is still the most important part of the diagnosis of gouty arthritis. A rapid onset of acute arthritis in an adult man after some characteristic provocations with complete subsidence in several days without residual symptoms is the standard of diagnosis. The dramatic response to colchicine therapy and an elevated serum uric acid are substantiating features.

History

Several points must be kept in mind if one is not to be misled. First, gout may affect any joint or bursa.

Hippocrates recognized this when he called the disease podagra, cheiagra, or gonagra depending on whether the big toe, wrist or knee joint were affected. It also may affect the upper extremities first. It tends, however, in early acute attacks to affect the peripheral joints. The bursa, too, may be affected, and olecranon bursitis should make one suspicious of gout. Second, gout may occur at any age from the second decade on. Younger patients are more likely to have a polyarticular onset. Third, gout may occur in women (5 per cent of cases or more) and then it often assumes atypical forms and superficially resembles rheumatoid arthritis. Fourth, a precipitating factor may often be found in the history of acute gouty arthritis such as surgery, emotional or physical stress, injections of liver or thiamine, diuretic drug use or recent excesses of food or alcohol. Fifth, renal calculi are commonly present in the past history.

Physical Examination

Physical findings with early arthritis are a very tender, warm, red, swollen joint with extension into neighboring soft tissues. Desquamation may occur. In chronic gouty arthritis, polyarticular swelling is present and, although less symmetrical, the joints are difficult to distinguish from those affected by chronic rheumatoid arthritis.

The finding of tophi is a relatively late finding, but should be looked for. The ear, olecranon bursa, and achilles tendon are the most common sites, but tophi may be found almost anywhere. A fever may be present with attacks of arthritis.

Laboratory

Laboratory results usually show a leukocytosis and an elevated sedimentation rate with attacks of arthritis, but these tests are normal in asymptomatic periods. A mild albuminuria and a decrease in renal function as evidenced by an elevated blood urea nitrogen may occur, especially with acute attacks of arthritis. Chronic gout often produces severe renal impairment. X-ray findings are positive for erosion in subchondral bones in only one-third of the cases of gouty arthritis, and then usually late in the disease. The usual x-ray finding is a normal joint in acute arthritis and hypertrophic changes in chronic arthritis.

Definite proof of the diagnosis of gout may be difficult in some cases. One should prove an abnormality of uric acid metabolism as one does with a glucose tolerance test in diabetes mellitus. One has no such tolerance test in gout. The serum uric acid is elevated at some time in the disease in 75 per cent of the cases with repeated testing. One probably can obtain a higher percentage of elevated uric acids if one uses a specific uricase determination of uric acid in the serum, which is the method employed by most research laboratories in the country. For practical purposes, one cannot rely on a normal serum uric acid to exclude the diagnosis of gout. Uricosuric drugs such as salicylates, steroids, phenlbutazone or its analogs, probenecid, ethyl biscoumacetate (tromexan) and bishydroxycoumarin (dicumarol) may falsify the test. Also during an acute attack of gouty arthritis, the serum uric acid tends to be lower than usual.

There are false positive elevations of uric acid which occur in the diseases previously mentioned as causes of secondary gout, psoriasis, chronic eczema, urticaria, and after tubular blocking diuretic agents such as chlorothiazide. The serum uric acid, therefore, is only an aid in the diagnosis of gout. The twenty-four-hour urinary excretion of uric acid is usually elevated in patients with gout,[8] but this test is rarely positive in patients without elevation of the serum uric acid.

A certain method for diagnosis of gout is the finding of a tophus and the proof of sodium urate crystals in the tophus by chemical means or polarized light microscopy. The urate crystals are dissolved in formalin so that absolute alcohol is necessary as a fixative for pathological study.

The examination of the synovial fluid from gouty joints holds promise of improved diagnosis. A recent report[9] showed positive doubly refractive, rod-like crystals. Two further methods to insure that these crystals are urates include polarized light microscopy and digestion with uricase.

Treatment of Gout

The treatment of gout depends upon the stage as well as the manifestation in that stage. Gout must be treated as a chronic disease with continued therapy for life, if the course of the disease is to be modified. The patient must be educated as to the cause of gout and gouty arthritis. The complications should be explained, as well as the aims of therapy. The patient's cooperation must be solicited and obtained.

Stage 1. Asymptomatic Hyperuricemia.—Although no therapy is mandatory at this stage, a diet with omission of the high purine foods and a uricosuric agent would be recommended to prevent potential complications. A large fluid intake to prevent renal calculi is also advised.

Stage II. Acute Arthritic Attacks with Complete Remission.—A diet eliminating the high purine foods, a uricosuric drug, and colchicine as a prophylactic arthritic drug would be advisable. This program has been proven effective in reducing the incidence of attacks.

Stage III.—Chronic Gouty Arthritis With or Without Tophus.—A diet of a low purine nature, a uricosuric drug, colchicine as a prophylactic arthritic measure and physio-therapy for joint stiffness and deformity would be advisable. This program has been shown to reduce the size of the tophus and to improve the chronic joint changes.[10] If ulceration of a tophus is imminent, it should be surgically excised. A large fluid intake would be advisable.

Treatment of Acute Gouty Arthritis

1. A low purine diet is recommended. Fasting is accompanied by a reduction in the excretion of uric acid in the urine and an elevated uric acid in the serum in the gouty and non-gouty patients. A pure fat diet has also been shown to increase the retention level.[11] Therefore, a low purine, low fat, high carbohydrate diet for acute attacks would be beneficial.

2. Absolute bedrest to relieve pain with protection of the joint by a cradle is effective. Hot or cold dressings may be helpful to selected patients.

3. There are many effective drugs for the treatment of acute gouty arthritis.

(a) Colchicine is a specific drug for gouty arthritis and effective in over 95 per cent of cases. The use of 0.65 mg. orally every hour or two until pain is relieved, or diarrhea, nausea, or vomiting occur, is the manner of administration. The sooner it is given in the attack, the more effective it is. The total number of pills for the therapeutic or toxic dose is usually constant, and this number or two less, if this is a toxic number, may be used again for succeeding attacks. Intravenous colchicine gives faster results with less side effects, but if any of the material is injected subcutaneously, a slough is likely to occur.

The exact site of action of colchicine is unknown. A new analog colcemide is too toxic for general use, as it may cause alopecia and blood dyscrasia. Colchicine is also used by most rheumatologists prophylactically, in a dose of 0.65 mg. once or twice a day to prevent acute attacks, with good results. Colchicine is used in this prophylactic dosage for chronic arthritis.

(b) Phenylbutazone (Butazolidin) may be used in place of colchicine in dose of 400 mg. initially and 200 mg. four times a day for three or four days. This will usually be effective, but it is not as specific as colchicine.

(c) ACTH (Corticortropin) may be used in conjunction with colchicine or phenylbutazone in doses of 40 to 80 units intramuscularly in the gel form two or three times a day for two days, but rebound arthritis may occur if it is used alone.

(d) Intraarticular injection of hydrocortisone will cause a non-specific suppression of the inflammation. This, too, should be used as an adjunct to colchicine or phenylbutazone.

4. A large fluid intake to prevent renal damage is desirable.

5. Maintenance of bowel function is of some value. Uric acid has been shown to be excreted in the gastro-intestinal tract with radio-active studies by Sorenson.[12]

The use of a laxative such as milk of magnesia is rarely necessary, due to the diarrheic effect of colchicine.

6. No salicylates should be used for the reasons explained below. Analgesic drugs such as codeine, darvon, demerol, or morphine may be needed.

Interval Treatment

1. A uricosuric drug should be used in all cases with an elevated serum uric acid or tophi. With the initiation of uricosuric drugs, attacks of acute arthritis may occur, so that colchicine prophylactically should be used.

There are several uricosuric drugs:

(a) Cincophen is judged by most physicians to be too toxic for general use, but may be used if all else fails in doses of 0.5 grams orally three times a day for three days a week.

(b) Five to six grams of salicylates daily may be considered an adequate uricosuric dose. Large doses of salicylates suppress tubular reabsorption of uric acid, moderate doses of salicylates depress tubular secretion and reabsorption and have little effect on ultimate uricosuria, but small doses suppress tubular secretion and hence produce a uric acid retention. Salicylates have the advantages of analgesia, low cost, and relief of morning stiffness as well as their uricosuric property. They also are the least likely uricosuric drugs to produce an acute exacerabation of arthritis. In my opinion, they are the best drug at the beginning of therapy. Their principal disadvantages are gastro-intestinal intolerance and the nuisance of the number of pills necessary. They also help

other forms of arthritis and therefore may interfere with a definite diagnosis.

(c) Procenicid (Benenid) blocks the reabsorption of uric acid. Salicylates in any dose block this effect and so must be avoided, if this drug is used. Procenicid is more potent than salicylates and may be judged safe after ten years of use. It rarely produces gastro-intestinal upset and drug rash. Its disadvantage is its expense. The usual range of dosage is 0.5 grams to 2.0 grams orally daily.

(d) Sulfinpyrazone (Anturan) is potent, but it is a sulfoxide analog of phenylbutazone (Butazolidin). The dosage here is 100 to 400 mg. orally daily. This is too new to be declared safe at present, as its parent drug has shown many side effects including duodenal ulceration, agranulocytosis, rash, edema, nausea, bloating, and vertigo on prolonged use. Salicylates block the uricosuric action of sulfinpryazone in any dosage.

(e) Zoxazolamine (Flexin), in doses of 250 mg. to 750 mg. daily, has potent uricosuric effects. Side effects have included drowsiness, light headaches, and gastro-intestinal symptoms. It is also expensive and too new to be declared safe for prolonged use, although it is apparently safe. Salicylates block the uricosuric action in any dosage.

2. A program of correction of concurrent obesity, if present, should be carried out. Weight reduction should be carried out slowly, and the patient should be warned that acute arthritis attacks may occur with this stress.

3. Colchicine prophylactically should be used in a dosage of 0.65 mg. orally once or twice a day.

4. A low purine diet or at least a diet eliminating the high purine foods and alcohol is recommended in most cases.

5. A large fluid intake is effective. Coffee and tea are not forbidden beverages as was believed in the past.

6. Treatment of uric acid calculi either pre-existing or occurring during therapy include the temporary reduction or stoppage of uricosuric drugs and the alkalinization of the urine. Sodium bi-carbonate, one heaping teaspoonful after each meal and at bedtime, usually accomplishes this well. A low purine diet probably should be advised in these patients.

Conclusions

1. Gout is a common, chronic disease of uric acid metabolism.

2. Although the pathogenesis of gout is unknown, much has been learned about uric acid metabolism.

3. The diagnosis of gout may be difficult, but careful attention to the history, physical examination, serum uric acid and x-ray findings in descending order of value will usually produce a presumptive diagnosis which will be confirmed by a trial of colchicine therapy for acute gouty arthritis or by proof of a tophus.

4. The treatment of gout depends upon the stage of the disease and the clinical and laboratory manifestations of that stage of the disease.

5. The treatment of gout is successful but must be continued for a long time, if attacks of gouty arthritis and other complications of gout are to be prevented, as there is no cure for the disease at present.

Summary

The reasons why gout is an important disease are presented. Some aspect of the abnormalities of the uric acid metabolism are evaluated. The clinical history, physical findings and laboratory findings leading to a diagnosis of gout are discussed. The principles of the treatment of gout including drug therapy are specifically enumerated for various stages of gout and certain common manifestations of the disease.

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Diagnosis and Treatment of Dissecting Aortic Aneurysms

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LAENNEC, in 1826, was the first one to use the term dissecting aneurysm. The process of dissection, however, was first described by Maunoir in 1802. Its grave prognosis is well known, and a large series by Shennan[1] shows that 35 per cent of the patients die suddenly or within a few minutes, 30 per cent lived from an hour to twenty-four hours, 27 per cent expire in the ensuing week, with only 8 per cent being alive beyond the first week (Table I). Some proximal dissection is present in virtually every case, and at times it is wholly proximal. Seventy per cent of dissecting aneurysms terminate in cardiac tamponade. Patients that survive do so mostly through rupture back into the aortic lumen. Re-entry phenomenon, so-called "healed" dissecting aneurysm, occurs in the aorta or in the pelvic arteries in about 15 per cent. The surgical correction used so far imitates this phenomenon. The success already attained has begun to change the gloomy outlook of these patients. The few reported series,[2-4] however, come from large institutions only, noted for their large surgical, diagnostic and research facilities. It is the purpose of this paper to show that dissecting aneurysms can be demonstrated and adequately treated in smaller hospitals, and to stress the importance of confirming the diagnosis of a dissecting aneurysm before thoracotomy.

TABLE I. SURVIVAL RATE OF DISSECTING ANEURYSMS

Die suddenly	35%
Dead within twenty-four hours	30%
Dead within a week	27%
Alive after one week	8%

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Case Report

Mrs. P. H. (Case 0-8387), aged 66, a colored woman, obese, hypertensive and diabetic, was admitted to the hospital on December 6, 1960, because of severe precordial and epigastric pain that started suddenly at 7:00 o'clock that morning while hanging some clothes. The pain was of tearing quality, constant with exacerbations lasting about five minutes and radiating through to the back. The patient vomited twice prior to admission. The past medical history revealed that the patient had been treated for moderate hypertension of at least twenty years' duration. Her uterus had been removed for "fibroids" in 1939 and she had two "strokes" in 1948 and 1956.

Physical examination on admission showed an obese patient weighing 204 pounds (ideal 149), in acute distress, complaining of pain. Blood pressure was 210/140, with subsequent readings of 180/100, pulse 84, respirations 20. The pupils were equal; eye grounds showed grade II hypertensive changes. The heart was not enlarged, had a normal sinus rhythm with occasional premature contractions, and no murmurs were heard. The lungs were clear. Examination of the abdomen resulted in negative findings, and no abnormal pulsations were felt. The reflexes were equal, and no pathological reflexes were elicited. Bilateral femoral pulses were felt. The rest of the peripheral pulses were not discernible. Both lower extremities felt warm. While diagnostic studies were being conducted, the patient required large and frequent doses of Meperidine to ameliorate the pain. The patient was tried on a strict ulcer diet because of an upper gastrointestinal series report of an irregularity in the lesser curvature aspect of the bulb thought to be consistent with peptic ulcer. The remainder of the laboratory data was as follows: Hemoglobin 14.5 gms. per cent; WBC 6700; segmented 81 per cent; lymphocytes 19 per cent. Urinalysis showed a specific gravity of 1.013, numerous RBC/hpf, albumin 2 plus. Serology revealed no abnormalities. NPN of 37 mg. per cent. BUN of 20 mg. per cent. Three-hour glucose tolerance showed a fasting blood sugar of 106 mg., 178 mg. at one-half hour, 224 mg. at one hour, 278 mg. at two hours and 179 mg. at the end of three hours. An electrocardiogram revealed a normal sinus rhythm with occasional premature ventricular contractions. There were ST—T wave changes consistent with diffuse myocardial damage. A routine chest radiograph showed dilatation and tortuosity of the aorta (Fig. 1). Because the patient failed to improve and the pain continued unabated, we were

asked to see the patient in consultation. Dissecting aneurysm was seriously considered, and on December 23, 1960, an intravenous aortogram was performed that showed the typical double contrast shadow considered diagnostic of dissecting aneurysm (Figs. 2 and 3). The double shadow extended from the transverse arch down to at least the level of the diaphragm. The patient was prepared and an exploratory operation was performed the same day.



Fig. 1.



Fig. 2.

Operative Findings.—A left posterior lateral incision was made, and the chest entered through the bed of the resected seventh rib. Inspection revealed a normal appearing descending aorta with only slight dilatation of the arch and the ascending aorta. A pair of intercostal arteries were divided and the aorta dissected free. Aortic clamps were then placed proximally and distally, the aorta divided between them leaving a small portion intact medially to prevent complete separation and to aid in closure.

A double lumen was found which extended 75 per cent of the circumference of the aorta. Within the false lumen, a large amount of soft, jelly-like clotted blood was evacuated. The separated layers of the distal aorta were repaired by approximating the intima, media and adventitia with a continuous arterial suture of 4-0 black silk. Proximally, a portion of the intima 2 centimeters in diameter was removed, producing a window between the false and true lumen of the aorta. The divided ends of the aorta were then anastomosed by approximating the adventitia of the proximal portion to the full thickness of the distal portion. Thus, we formed an intimal window, allowing blood which entered the false lumen to re-enter into the true lumen of the aorta. The total occlusion time was twenty-nine minutes.



Fig. 3.

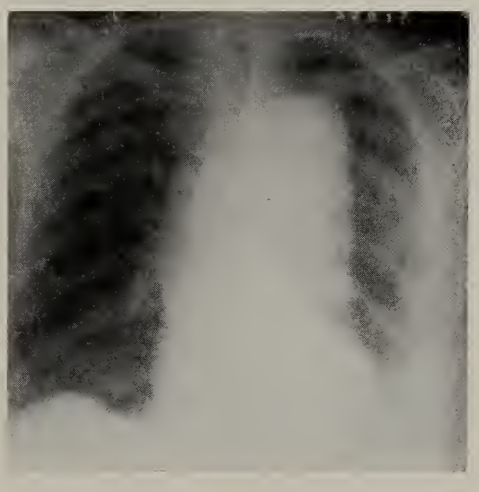


Fig. 4.

Postoperative Course.—The patient tolerated the procedure well, had no complications and the chief complaint of pain was no longer present. The patient was discharged and is doing well. Postoperative chest radiograph showed on appreciable change (Fig. 4).

Discussion

Dissecting aneurysms are not similar to other aneurysms of the aorta. In the majority of cases, rather than an external dilatation of the wall of the aorta, there is a hemorrhagic intramural separation of the adventitial and intimal layers. The false lumen so produced communicates with the true lumen through an intimal tear. The etiology is unknown.

Pathologically, degeneration of the media is found. It is felt that the lesion develops as a rupture of one of the thin-walled vaso-vasorum into the area of medial necrosis with secondary rupture of the intima. The force of the blood through this intimal tear separates the adventitia from the intima. As the dissection progresses, the pressure may be great enough to occlude the intimal lining of the various aortic branches. It is not uncommon for one to observe cyanosis of the extremities.

The most characteristic symptom of a dissecting aneurysm is its sudden onset. There is usually intense pain which may originate retrosternally and then characteristically progresses to the neck, back and down into the abdomen as the force of the stream of blood separates the aortic layers. The pain is described as being tearing in nature and has been compared with a red hot fire being thrust into the chest (Shennan).

If pain is produced by the actual dissection, the dissecting process in our patient was probably very slow to explain the duration of pain (seventeen days) and the very extensive dissection found at operation. The patient reported by Gilman and Baily[3] was still having pain when operated upon the eighth day, and also had a very extensive dissection. Of the seventy-nine cases of old "healed" dissecting aneurysms included in the series of Shennan, the process was confined to the arch in only eleven cases (14 per cent). If the above reasoning is correct, it follows that our patient could conceivably have "healed" herself, if left alone.

The width of the sac in our patient was nearly complete; it is realized that it can vary at different locations in the same dissection. In fifty-five cases in the series of Shennan, where width of the sac is given, fourteen completely surrounded the aorta, sixteen were nearly complete, in the remaining twenty-five cases the dissection occupied from 33 to 75 per cent of the circumference.

The technique of intravenous aortography as originally developed by Robb and Steinberg[5] is very simple. With the patient in the right posterior oblique position, 12-gauge needles are placed into the median anticubital veins of the left and right arms. A preliminary injection of sodium dehydrocholate† provides an accurate means of determining the circulation time. Simultaneous 1 mg. per kilogram of 90 per cent sodium diatrizoate* is injected intravenously, as rapidly as possible. Serioroentgens, four seconds apart, are then made, starting two seconds before the circulation time.

Serial exposures can easily be performed, and we have been able to obtain four exposures within a 15-second period without the use of a mechanical film changer, changing the films by hand.

TABLE II. LOCATION AND TYPES OF DISSECTING ANEURYSMS

	Shennan	*DeBakey & Cooley*
Limited to arch	41%	2%
From origin of aorta to descending aorta	35%	7%
Originating just distal to subclavian artery	21%	91%
Originating in abdominal aorta	3%	—

We cannot stress too greatly the importance of confirming the clinical diagnosis of a dissecting aneurysm by aortography before thoracotomy. We have witnessed a case in which a dissecting aneurysm was diagnosed clinically; however, at thoracotomy, the ascending aorta appeared to be normal, and the surgeon closed the chest, thinking the clinical diagnosis to be wrong. The patient died three days later. At autopsy, the patient was found to have an extensive dissecting aneurysm with cardiac tamponade. We must remember that this is an internal aneurysm, and the gross appearance of the aorta at thoracotomy may be normal. Thus, the surgeon with only a clinical diagnosis may hesitate to divide the aorta.

The surgical technique employed in our case is applicable in dissections that extend beyond the arch which constitute 56 per cent of the cases in Shennan's series, but 73 per cent of the cases in DeBakey's[4] studies. The extent of dissection in the 297 cases of Shennan remained limited to the arch in 121 cases (41 per cent). It extended from the origin of the aorta or the arch to the descending thoracic aorta or beyond in 104 cases (35 per cent). It originated in the thoracic aorta just beyond the left sub-

†Decholin, Ames Company, Inc., Elkhart, Indiana.
*Hypaque, Winthrop Laboratories, New York City.

clavian artery in 62 cases (21 per cent). In only 10 cases (3 per cent), the dissection originated in the abdominal aorta (Table II). The 41 per cent of cases where the dissection is limited to the ascending aorta and arch could conceivably be helped by the technique suggested by Gilman and Bailey.[3]

Summary and Conclusions

An extensive dissecting aneurysm of seventeen days' duration, with survival after surgical treatment, is presented. The simultaneous double intravenous method of opacification of Robb and Steinberg is thought to be safe, simple and adequate for the demonstration of dissecting aneurysms. We have stressed the importance of confirming the clinical diagnosis of a dissecting aneurysm by aortography previous to surgery. A dissecting aneurysm can be properly diagnosed, demonstrated and adequately treated in other than large institutions.

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Doctor's Own Words May Prove His Negligence

Statements made by a gynecologist to a patient and her husband after an operation were sufficient to provide expert evidence of negligence in diagnosis to submit to a jury. A dismissal of the patient's damage suit for lack of evidence was reversed on appeal by the Oklahoma Supreme Court.

Consulted by the patient, the gynecologist made tests and determined that she was not pregnant but has a tumor which should be removed immediately. Upon operating, however, he found that she was, in fact, pregnant. The patient testified that, after the operation, the gynecologist said to her, "I'm sorry, I should have made more tests on you." Her husband testified that the gynecologist said, ". . . this is a terrible thing I have done, I wasn't satisfied with the lab report, she did have signs of being pregnant. I should have had tests run again, I should have made some other tests. I'm sorry."

Although there was no expert testimony that the gynecologist was negligent in making his diagnosis, the appellate court held that the testimony as to his admissions was sufficient to go to the jury. Two justices dissented, stating that, although the gynecologist recognized that he had made a mistake after the operation, his statements did not amount to admissions of negligence.—*Greenwood v. Harris,* 362 P. 2d 85 (Okla., May 31, 1961)

Benign Gastric and Duodenal Ulcer

A *Multi-Complex Disorder*

Milton W. White, M.D.
Detroit, Michigan

CONSIDERING the benign ulcer, gastric or duodenal, as a single etiological disease is no longer tenable. Accumulative studies, as well as clinical evidence, has convincingly demonstrated the co-existence of a number of abnormal pathologic and physiologic changes. Because of such findings the ulcer must be looked upon as a multi-complex disorder which may be instigated by one or more etiologic factors. It would seem inadequate, too, if in therapy attention is directed solely toward a single cause.

Currently, the theory of gastric hyperacidity is rather commonly accepted as the major malfactor behind the etiology of the ulcer. Because of such single accepted theory the ulcer is generally being treated primarily through medical or surgical intervention in methods aimed at reducing or removing the acid content or portion of the stomach.

Of interest, however, is the number of current failures in the realm of medical therapy. It is alleged by many prominent authorities that 15 to 20 per cent of all those who develop an ulcer will ultimately develop a chronic state; that the others will heal because of or in spite of prevailing therapy. It is in the chronic group that the antacid therapy fails to follow a consistent or dependable course. Recurrence, non-healing, intractability, complication, and a guarded prognosis are all too common.

Surgery has its troubles too. The recurrent symptoms, stomal ulcers or the various postoperative complications are being rationalized in many ways such as gastritis, insufficient stomach removed, incomplete vagotomies, wrong type of gastrointestinal continuity, et cetera. This merely attests to the fact that though surgery is often helpful and necessary in cases of obstruction, perforation, uncontrolled bleeding or marked intractability, it is not predictably certain of a satisfactory end result when used as an elective routine procedure.

Hyperacidity, which may play a part in the formation of the ulcer, is apparently not the only offender. It cannot, for example, account for the localized character of the ulcer, nor does it explain the ulcer in stomachs that are relatively free of acids. In fact, there are many clinical instances of cases with proven ulcers, in which foods or alkalies do little good in relieving the symptoms—oftentimes aggravating them instead. We must, therefore, take a broader approach to the benign ulcer problem and attempt to evaluate the significance of the various other factors and changes that are present.

Based upon clinical experience, roentgenologic, experimental and recent pathologic studies, abundant evidence presents itself to demonstrate clearly the fact that the ulcer is a multi-faceted disorder. Speaking in terms of etiology alone will overlook other pathologic conditions that might be concommitantly associated. The ulcer problem, too, in therapy must include consideration of the pathologic changes present, as well as the etiology. Nor does the problem end at this point, either. For, as consistently shown by x-ray studies, abnormal motility is frequently associated. It would seem logical therefore to expect inadequate results in therapy if any one or several of these conditions were left unresolved. The knowledge of the pathologic, etiologic, and abnormal physiologic forces behind the production of the benign ulcer is of upmost importance. Let us review such findings.

Pathological Consideration

Study of 100 resected stomachs performed for gastric and duodenal ulcers, both grossly and microscopically by the author,[1] plus the results of 600 stomachs by Magnus[2,3] and work by European investigator Alfonso DeLaFeunta Choas[4] of Madrid has revealed the following information:

1. *Lymphocytic Infiltration.*—Nearly all stomachs resected showed vast infiltration of lymphocytes around the blood vessels, ulcer bed and especially the mucosa where gastritis was associated.

2. *Eosinophilic Cell Infiltration.*—A number of cases showed extensive eosinophilic infiltration.

3. *Necrosis.*—Microscopic examination revealed many instances of endarteritis obliterans (closure of

the endarteries), although the venules were loaded with blood cells.

4. *Edema.*—The mucosa was in most cases edematous involving the ulcer bed, the surrounding mucosa and submucosal layers.

5. *Cicatrization.*—Large number of fibroblasts and scar tissue cells were noted in many cases, though healing was incomplete.

Comment

Lymphocytes Usually Indicate a Chronic Inflammatory State.—The latter may arise, however, not only from mechanical, chemical, or thermal irritants, but from bacterial infections as well. There is a tendency to believe that the hydrochloric acid in the gastric juice is capable of destroying all pathogenic bacteria entering the stomach. This is far from the truth, as experimental work has shown. The existence, too, of pus and pyogenic membranes as seen grossly on a number of resected stomachs likewise indicates bacterial involvement. Of course aseptic material such as croton oil, turpentine, and gastric acidity (?) may produce suppuration, but in light of the limited area of ulceration penetration, posteriorly or anteriorly to the surrounding organs, and the spread to the lymph nodes in the adjacent areas, it would seem unwise to overlook a mucosal or submucosal bacterial invasion.

Illustrative Cases

J.N., aged thirty-five, had a long history of irregular episode of indigestion and dyspeptic symptoms. X-ray studies some while back revealed the presence of a duodenal ulcer. The usual ulcer diet (Sippy's), anticholinergics, sedatives, alkalies, hospital rest and care failed to relieve his distress. Inclusion of an antibiotic (Mysteclin) provided an almost dramatic relief of symptoms and the patient felt comfortable for the first time in months.

J.R., aged twenty-nine, suffered from a severe deviated septum and hypertrophied turbinates. There was a constant postnasal drip. J.R. had to expectorate frequently, and upon many occasions swallowed some of the discharge. He developed a duodenal ulcer which recurred from time to time. On advice he had the nasal condition corrected by surgery. He has been free of gastrointestinal pain and distress now for a number of years.

Smith and Rivers[5] cite the following case:

A five-year-old-girl was seen because of a bleeding duodenal ulcer. She had an associated acute tonsillitis. Gastric acidity was not unusual and a study of peptic acitivity was normal. The tonsils were removed and cultures made from them were injected into experimental animals. Multiple acute ulcerations and submucosal hemorrhages promptly developed in the gastro-intestinal tissues of these animals. The patient was placed on a bland diet and had no further recurrence of her hemorrhage.

Eosinophilic Cells Usually Indicate an Allergenic or Parasitic Reaction.—Endemically we are not too greatly concerned with parasites, but the possibility might exist and consideration of this factor should be maintained. On the whole, however, strong attention must be directed to the presence of an allergenic reaction. Some reactions may be so severe as to send the patient into anaphylactic shock. Walter Alvarez[6] describes such a case in which a woman patient went into complete collapse following the ingestion of Roquefort cheese hidden in a salad. He mentioned cases, too, of lesser severity of gastric or intestinal distress which cleared simply by omitting the offending substance (when identified) from the diet of the patient.

Distress usually arises from one food allergen. In many instances a multiple number of food sensitivities may be present. Drugs consumed orally or taken by injection may be similarly involved. Inhalant pollens may play a part. The degree and site of reaction are variable and dependent upon the region and type of tissue involved. Thus chelitis, stomatitis, canker sore, apthous ulcers or blebs may be the result of a food or drug taken orally. I have an epileptic patient who suddenly developed a hypertrophic gingivitis after taking diphenylhydantoin sodium (Dilantin) harmlessly for many years. Withdrawal of the medication gave complete relief. Cyclic vomiting, severe cardiospasm, or pylorospasm may follow the ingestion of a specific food or a hypodermic injection. I have witnessed a severe shock-like reaction, associated with epigastric distress, in a patient who had received a small amount of meperidine (Demerol) and another case following the ingestion of milk.

Gastro-intestinal hypersensitivity to foods or drugs is a definite entity in the ulcer formation that is not to be minimized. Of great importance, therefore, is the need to realize that besides gastric or intestinal spasms, local anaphylactic irritation and ulceration is possible. And like those individuals who develop hypersensitive spots in the skin known as the Arthus reaction, so is it possible for those whose shock organs are in the stomach or duodenum to form a local anaphylactic spasm accompanied by edema, bleb, pain, and some bleeding in that area.

Kern and Stewart[7] were among the first to suggest a peptic ulcer-allergy relationship. Since then many others followed illustrating this association with specific case studies. L. P. Gay[8,9] writes about one of his patients as follows:

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Miss G.P., aged twenty-one, had ulcer symptoms for two years, hunger pains relieved by soda-bicarbonate, night pains requiring food or alkalies. Two years before dyspeptic symptoms her appendix was removed because of right lower quadrant pains. Gastric analysis revealed a marked hyperacidity and x-ray showed a markedly deformed duodenal cap. Patient was put on a conventional ulcer diet consisting of milk, eggs, cereals, gruel, custards with frequent feedings and administration of alkalies. Instead of improving, the patient's symptoms became aggravated. She experienced much vomiting. Removal of wheat, eggs and milk from her diet gave almost instantaneous relief and she has remained well for over two years.

This illustration is not an isolated one. Numerous other examples were given.

In my own experience, two cases were particularly dramatic.

D.O., aged fifteen, presented himself because of fainting spells, marked pallor, tarry stools for about one week although epigastric distress was present for over a year. He stated that milk and foods gave him temporary relief, discomfort returning one or two hours later. He was hospitalized and x-ray studies revealed an active duodenal ulcer. Treatment was immediately instituted, blood transfusions, antispasmotics, Sippy diet, bed rest, vitamins, et cetera. His bleeding ceased and the patient was sent home to convalesce. He was seen at the office for the next five weeks, and although there was no recurrence of the bleeding he continued to complain of epigastric distress, relieved particularly by milk, only to recur in an hour or so. A food survey soon revealed that distress seemed to occur most consistently an hour after consuming milk. Discontinuing milk from the patient's dietary led to a dramatic cessation of epigastric distress. This was the first time he had been free of pain in over a year. His relief has continued for the past two years.

F.I., aged fifty-six, suffered from chronic bronchial asthma. He had developed a gastric ulcer a year previously. The ulcer healed under close medical care but distress seemed to recur at different intervals. No particular foods seemed to be involved. Once when his asthma became particularly bad he was given an intravenous injection of aminophyllin. That day he developed a typical ulcer syndrome, pains in epigastrium, bloat, distention and a recurrence of the ulcer. On questioning, it was found that he had been taking a tablet medication for years in order to combat his asthmatic episodes. Investigation revealed that the tablet contained aminophyllin. Eliminating this drug gave him dramatic relief for the first time in years. He has been free of distress now for over a year.

Necrosis Usually Indicates Ischemia.—This is a rather startling finding, particularly when the collateral circulation of the stomach and duodenum is so vast. Yet numerous pathological slides revealed a lesion similar to "endarteritis obliterans." European investigator, Alfonso DeLaFeunta Chaos,[4] of Madrid examined several hundred specimens by perfusions with Neoprine (India ink) and demonstrated a zone of intense ischemia. Microscopic sections revealed closures or occlusion of the arterioles in the ulcerative area although the venules were dilated and occupied with red blood cells. Boyd[10] believes peri-arteritis to be part of the inflammatory process. He also states that it is often associated with thrombosis. Needless to say, whatever the inciting cause, there exists an apparent closure of the end arteries with a fibrinoplastic or foreign protein-like substance. The flow of arterial blood is consequently hampered and adequate healing prevented.

Edema Is Usually Found in Association with Inflammatory Assaults.—It may, however, be in association with increased Na^+ or Cl^- retention. Hypoproteinemia may be a factor too. Since humans erroneously consider salt a neutral or inert chemical, which is far from the truth, attention must be directed to the danger of this substance's overuse. Coller[11,12] and his associates have shown that the stomach wall of the dog may become quite edematous if an excess of salt is given. Areas of local tissue damage or injuries are prone to select extra sodium ions, too, and consequently contribute to further edema. Furthermore, edematous tissue is apt to slough with repeated irritations or when exposed to hypertonic foods or fluids. It is also vulnerable to infections leading to acute or chronic degrees of local cellulitis.

Cicatrization without Complete Healing Suggests Some Form of Interference with the Process of Granulation.—All factors promoting such a situation must be considered, i.e., roughage in dietary, hyperacid producing, spicy, hypertonic foods, deficiency of vitamin C, K, hypoproteinemia, ischemia, and the like.

Etiologic Consideration

Determining the etiologic source is unquestionably of extreme importance. Despite voluminous recordings and research efforts, however, the exact cause for the ulcer still remains an uncertainty. Experimentally, scientists have convincingly demonstrated the relationship of ulceration to increased concentration of gastric acids and pepsin by their works on dogs. In the human being, however, though hyperacidity may play a part, we cannot be certain that it is merely a perpetuator or reactivator of an ulcerative condition already present from some other cause.

It is very likely that almost any factor (chemical, thermal, mechanical, or infectious) may have the capacity, in some individuals, to instigate the chain or

events leading ultimately to the chronic ulcer. Lowered mucosal resistance may be a possible reason why some individuals are more susceptible to gastric or duodenal irritation. Lowered mucosal resistance is associated with the viscosity of the mucus secreting glands. Greater viscosity means more protection against irritants. Aspirins, for example, are known for their ability to produce dyspeptic symptoms or hematemesis in many individuals, whereas others are distressed none at all. Alvarez and Summerskill,[13] investigated the relationship between massive gastro-intestinal hemorrhage and salicylate consumption. They found a majority of those bleeding had taken aspirin tablets within twelve hours of their hemorrhage. Occult blood loss in stools occurred during periods of salicylate consumption in 50 per cent of patients with benign ulcers. Undiluted alcohol, hot spicy foods, hypertonic salt foods ingested and certain drugs, may produce a gastric or duodenal erosion. Since many individuals can consume such foods or drugs with impunity, it must be assumed consequently that the others must have some localized loss of mucosal strength, or decrease in viscosity of the mucus secreting substance.

Chronic gastritis has been postulated with some credibility as being a forerunner to the ulcer. Although there is no evidence to substantiate this theory, proof exsits that most ulcers are concomitantly associated with localized or severely generalized forms of gastritis. It is very difficult to differentiate clinically from the symptoms presented between an ulcer and gastritis. An x-ray is necessary to help establish the diagnosis. Even then, several of the resected stomachs studied failed to reveal a gastric ulcer despite a diligent search by the pathologist (grossly and microscopically), although extensive gastritis was present. If gastritis cannot be considered as a primary source for the ulcer, it certainly must be included as a secondary associate.

Since Virchow's time, vaso-spasm has been proposed frequently as an important etiologic factor in the ulcer. However, the lesion in itself is not conclusively suggestive of a systemic vascular disease. Other causes such as inflammatory reactions, chronic infections, and ulcerative lesions may frequently lead to such a local arteriolar closure. Histamine local bleb may occur in the gastro-intestinal tract, too. Credibility is enhanced by the finding of eosinophilic cells microscopically in many stomachs resected because of an existing ulceration.

Factors such as stress, shock, over-fatigue, burns, neurogenic lesions, et cetera, have been known to lead to or to reactivate a benign ulcer. Curling's ulcer in children following burns and Cushing's writings recording ulcerations following lesions of the central nervous system are all too well known. There is the recent hypothesis that these conditions arise because ACTH is released from the pituitary gland which, in turn, activates the adrenals to secrete a steroid (cortisone) which, in turn, causes an increased hydrochloric acid content in the stomach. Hirschowitz,[14] however, through careful study refutes this theory by demonstrating that there is an associated decrease in the viscidness of the mucus substance lining the stomach wall. Though stress may initiate or reactivate an ulcer, it is my belief that it arises because the steroids produced, in response to an alarm reaction, have the capacity to cause a sodium ion retention and a potassium ion excretion. Increased retention of the sodium ion in the cell will lead to an edematous state. Consequently, a lowered mucosal resistance (edema of cells plus a lessened viscosity) is a possible complication.

Infections, toxins, et cetera, are known to initiate severe gastric distress. Although the bacterial growth is not as intense as in the intestinal area, the stomach and duodenal mucosa is not invulnerable to various pathogenic invaders. Hydrochloric acid is not completely bactericidal. There are many organisms whose growth, once established, is enhanced in an acid medium.

Abnormal Physiological Consideration

The radiograph and fluoroscope have been extremely valuable in demonstrating the existence of tone, motility, and spastic changes in the stomach and duodenum in association with ulcerative disease. Hypertonia is stated to exist if there is more than five peristaltic waves appearing simultaneously in the stomach. Irritability of the duodenum is indicated by hypermotility, and spasm of the stomach or duodenum is recognized by a persistent contraction. Lately the term pyloroduodenal spasm has come into use. This indicates that most likely the antrum, pylorus, and duodenum act more like a unit and the entire area is spastic at one time. In the stomach, if there is an ulcer present, there may be a spastic area diagonally opposite the irritated site. Pyloroduodenal spasm is most likely related to an inflammatory process in the immediate area.

Changes in motility or the appearance of spastic reactions are not always only indicative of ulcer disease. Neurogenic, reflex stimulation or allergic manifestation (without bleb formation) may produce such

a response. Whereas hypermotility is not usually painful, hyperspasticity is definitely so. Consequently many individuals may suffer intense epigastric distress yet have no organic changes. When an ulcerative condition is present it is often difficult to evaluate whether the pain is due to the ulcer itself or to the corresponding gastric or pyloroduodenal spasm that may be associated. Elimination of the spasm and hypermotility must be effected, however, for like the anal ulcer, control of the pain and healing is difficult unless such spasticity is corrected.

Therapeutic Objective

Since it is practically impossible with present-day facilities to determine the total or exact makeup of the chronic benign ulcer, it is apparently necessary to treat all cases as if they hypothetically possess any one or all of the factors in the etiologic, pathologic, and physiologic abnormalities previously discussed. Failure to follow such a plan may invariably leave one or several factors unchanged, contributing in many instances to an ineffective or inconsistent end result.

Therapeutic Management

Pathologic changes, as previously discussed, suggest the presence of an allergic state, chronic infection, possible *Endamoeba histolytica* infestation, endarteritis obliterans (of the ulcer wall), edema, and a vitamin C and/or hypoproteinemia. Measures must include means whereby all these factors are corrected.

Consideration is first directed to the allergy problem. If no specific relationship is apparent then the patient must be placed automatically at the onset of therapy, on a milk, egg and wheat-free diet. This statement may be relatively revolutionary inasmuch as current treatment is singularly dependent upon these latter foods. Many investigators, however, concur in the fact that the common offending allergens are most often wheat, milk, and/or eggs in that order. There are other foods, of course, or drugs, too, whereby the hypersensitiveness may produce the anaphylactic spastice focal reactions or acute exacerbation of the ulcer. Citrus fruits, coffee, chocolates, fish, various condiments, i.e., are frequent offenders. When identified or suspected, then they too must be eliminated. Those who are allergic to milk and must remain on a milk-free diet should have a substitute for it in order to prevent a calcium deficiency. Soy bean preparations are satisfactory, otherwise calcium wafers or tablets plus a vitamin D supplement to aid assimilation, may suffice.

Individuals who have gastro-intestinal allergy unfortunately do not usually give an immediate or a violent reaction. In fact, offending foods many times have a tendency to relieve the symptoms present when first ingested only to reach a state of anaphylactic spasticity one or two hours later. Similarly, the hypersensitive food or drug may be taken at intervals with complete impunity, accounting perhaps for the recurrent seasonal distress in some individuals. To explain the variable symptomatology, L. P. Gay[8,9] states "that when the reaction is not immediate, the gastric acidity is reduced at first by the food only to produce the anaphylactic spasm or pain an hour or two later." "Impunity may occur," he continues, "when there is an exhaustion of the reacting bodies to the allergenic foods automatically terminating the attack. When these bodies re-accumulate to the reacting level, the attack recurs. Withdrawal of the offending bodies from the dietary for a period of three to six months will permit ingestion of the offending substance without distress for a while, that is, until the antibodies again accumulate to a reacting level."

Antibacterial treatment is next in order. I have found the tetracyclines useful. To avoid a rectal monilial overgrowth, tetracyline may be combined with nystatin. If *B. coli* is suspected, a "sulfa" preparation is helpful, provided the patient is not allergic to the drug. Upon many occasions the use of foreign protein injections have given beneficial results. Sterile milk, proteolac, histidine monohydrochloride injected intramuscularly in appropriate doses are of extreme benefit at times.

If amebiasis is suspected, though not conclusively proven, a short course of an oral or intravenous amebicide may be tried. I have used Emetine hydrochloride 0.06 gms. intravenously on alternate days for six to twelve doses. This drug is not only effective against amebas but also seems to destroy a number of the secondary bacterial pathogens present. Of course if there is an arsenical idiosyncrasy the drug should not be used or immediately discontinued.

Necrosis (local enarteritis obliterans) is the next problem in order. In therapy I have successfully used the various proteolytic enzymes presently available such as Chymar (Armour) or Parenzyme (National Drug). They can be given intramuscularly as an aqueous suspension on alternate days for a number of weeks. The oily solution is avoided because of the danger of a skin sensitivity. Sublingual or oral tablets may be given beneficially afterwards.

Because of the prominent part edema plays in the pathological make-up of the ulcer, all the factors which may irritate or promote edematous tissue must be

carefully reviewed and effectively controlled. Harsh, gritty, hypertonic, or spicy foods must be avoided of course. And since hypoproteinemia and sodium and/or chloride (in excess) may lead to further edema, these two situations must be controlled. A high protein diet, chopped or grated in the earlier part of the treatment to a well chewed dietary low in salt is indicated. No one would conceivably pour a hypertonic salt solution upon an open wound yet this is what is happening when the salt intake is left to the uncontrolled and injudicious taste of the patient. Since hypertonic salt solutions are quite capable of not only irritating damaged tissue but of promoting further edema, likelihood of a cellultis and, of course, failure in healing, will be likely. I have found that a maximum intake of 1200 mg. of Na^+ is quite safe under physiologically stable circumstances. However, if marked perspiration occurs because of hot weather or from excessive muscular activity, an increase in salt intake is essential. Similarly, persistent vomiting or diarrhea, gastric, intestinal suction or a fistulous drainage, if present, will need an increased but calculated salt intake in order to maintain electrolyte equilibrium. On the other hand, if steroids are necessary or in times of stress, or following surgery, severe burns, emotional tensions, and the like, the ulcer patient must be immediately placed on a restricted Na^+ or Cl^- intake of approximately 600 to 800 mg. daily. For under these circumstances the body tends to retain sodium and to excrete potassium.

Faulty healing, excessive scar formation, insufficient granulation formation, may exist or persist because of a vitamin C deficiency, or perhaps from gastric hyperacidity, and spicy or gritty foods. Consequently, a dietary should include a high vitamin C intake. The tablet is sufficient since many individuals are allergic to the citrus fruits. Antacids may be utilized but in a limited daily intake. Preference is given to the liquid form of aluminum hydroxide. For those who are constipated, Maalox, Amphogel, or Gelusil is used. Two teaspoons in water between meals and at bedtime is sufficient. Its use is not only for the neutralization effect but the coating one as well. For those who have a tendency to loose stools, Basojel in the same amount is used. On a number of occasions, allergic reactions have occurred following the use of antacids. If such a situation occurs, antacids by all means must be discontinued. Care, too, must be exercised for, after excessive alkali usage, renal calculi or alkalosis may occur.

Abnormal physiologic manifestations as hyperspasticity, hypermotility and hypersecretion are invariably constant companions in association with most ulcer cases. It is assumed that the parasympathetic (vagus) chain is highly irritable under these circumstances and is consequently responsible for these irregularities. Failure to control this situation may account for the presence of distressing pains (even though the ulcer may be healed). It may also lead to various digestive disturbances in the lower intestinal tract because of the rapid propulsion of partly digested foods from the stomach proper. There is little question that some form of anticholinergic medication is indicated. The number of drugs in current use is legion. It would be too voluminous to include them all in this article. The oldest form of medication and still somewhat effective is of course, the tincture or powered extract of belladonna. There are many patented product preparations on the market, a number of them in combination with phenobarbital or other sedatives. The variety and amounts used can be found listed in the *Physician's Desk Reference*. I have found prochlorperazine as the dimaleate (compazine) given as a tablet 5 mg. q.i.d. (as a spansule 10 to 15 mg.) taken morning and night, or isopropamide as the iodine and prochlorperazine as the dimaleate (Combid) to be of decided effect for its anticholinergic and antispasmodic ability. The side effects are minimal, except for occasional drowsiness.

Though the immediate results of effective therapy in the benign ulcer may be good with prompt relief of symptoms and complete healing of the ulcer, little satisfaction can be maintained if recurrences are frequently encountered. The possibility of a lowered mucosal resistance must be remembered, and continued dietary discretion followed.

All possible sources contributing to repeated bacterial infections must be eliminated. Conditions such as sinusitis, deviated septi or enlarged turbinates, associated with marked post-nasal drainage, chronic hypertrophic tonsillitis or adenoiditis, chronic enteritis, et cetera, should receive the proper medical or surgical correction whenever possible.

All allergenic foods or drugs must be searched for. In many instances the individual may be allergic to two or more ingredients. Drugs, similarly, must be suspected, particularly any which may have been taken previously for a long period of time with impunity. This may even apply to the various antacids consumed. One must remember too that the allergen can at intervals be taken without giving symptoms.

During unusual periods of stress sedation is necessary, but equally important is the need to place the

individual on a low salt, non-irritating bland diet. Liquid antacids may be used in small amounts for their protective coating.

Summary

Acceptance of the theory of gastric hyperacidity as the sole malfactor behind the pathogenesis of the benign ulcer, gastric or duodenal, is no longer tenable. The ulcer is a multi-faceted disorder. The factors that are involved in this disease include the following: (1) allergic or parasitic reaction, (2) chronic bacterial infection, (3) local fibrinoplastic closure of the arterioles, (4) edema (Na^+ and/or Cl^- excess or hypoproteinemia), (5) faulty healing (vitamin C deficiency, hypoproteinemia, et cetera), (6) hyperspasticity, hypermotility, and (7) lowered mucosal resistance.

Because of the strong allergy element in the pathogenesis of the benign ulcer and the fact that milk, wheat, or eggs stand relatively high as the most common antigens, the patient will by necessity have to be placed on milk, wheat and egg-free diets, at the onset of treatment, at least, until the exact offending ingredient or ingredients can be identified. This change is rather startling inasmuch as these foods currently form the basic ulcer dietary.

Conclusion

Treatment of the benign ulcer cannot be confined to a single etiologic force. Emphasis must be directed to the fact that the ulcer is a complicated syndrome involving more than hyperacidity as is commonly believed today. The suggested broader-range treatment, when adequately applied, will be effective particularly for those who have not responded well on the widely-used Sippy or other antihyperacidity programs. Under this enlarged program of treatment, pathologic, abnormal physiologic and etiologic considerations all come under careful scrutiny. Only by treating and thereby controlling the abnormal forces in their entirety can there be hope of a more consistent and prognostically reliable outcome among benign gastric and duodenal ulcer patients. It would behoove us to discard the term "peptic" inasmuch as the word is misleading and falls far short of identifying the actual disease process.

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Ulcer

In 1935, three out of every 1,000 Americans were ulcer victims. In 1960, 14 out of every 1,000 or 3 million Americans were victims, a 400 per cent increase. In that year, the ulcer had cost the U.S. 12 million workdays, 500 million dollars and 10,000 deaths.

All of this indicates that the ulcer is not a "glamorous" disease, not even a simple nuisance disease. "It's a dangerous, painful and costly ailment that deserves far more realistic public attention and understanding than it has ever received."—C. J. TUPPER, M.D., Assistant Dean, University of Michigan Medical Center.

Acute Renal Failure

With Particular Emphasis on Management During Infancy and Childhood

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ACUTE RENAL FAILURE with associated anuria can occur at any age. The syndrome is only occasionally associated with lesions that cause irreversible renal damage, such as bilateral occlusion of the renal vessels or cortical necrosis. Most acute renal failure cases, however, are due to a reversible lesion, acute tubular necrosis. This may result from such insults as heavy metal or carbon tetrachloride poisoning as well as shock, crush injuries, or mismatched blood transfusions. Among children, one of the most frequent causes of anuria is acute glomerulo tubular nephritis.

The physician who is confronted with the sick child who has diminshed urinary output must determine at the onset whether the oliguria is due to obstruction, and if it is not, whether it is due to dehydration or due to actual renal insufficiency. In order to rule out the presence of obstructive uropathy, the physician should employ a uretheral catheter and might ultimately use the cystoscope and ureteral catheters, for complete obstruction can create the illusion of renal failure even when the kidney is capable of producing an adequate urinary output.

In the patient free from obstruction, the physician must determine whether the oliguria is due to dehydration or to renal injury before any treatment is instituted, for in dehydration fluids are indicated whereas fluids in renal failure may endanger the patient's life. Dehydration is manifested by signs of decreased tissue turgor and a concentrated urine. In renal failure, the urinary specific gravity is invariably low. One cannot overemphasize in any case of low urinary output the necessity to rule out urinary obstruction and to determine the specific gravity of the urine.

Once the anuria has been established to be renal in origin, the treatment is essentially the same in all cases, for the physician often at that time cannot determine whether the child has an irreversible condition or whether he is suffering from acute tubular necrosis which, if properly treated, should rarely be fatal. The cause of death in these cases is usually due to overhydration, hyperkalemia or superimposed infection and it is imperative that a program of management be followed that will prevent or minimize these serious complications.

General management during the anuric phase is directed toward: (1) Accurate management of fluid balance. (2) Prevention of infection. (3) Prevention of hyperkalemia. (4) Maintenance of adequate caloric intake.

Fluid Balance.—The most frequent complication of acute renal failure is over-hydration and drowning of the patient. When the physician is called to see this sick patient with fever, vomiting, diarrhea, and low urinary output, his first impulse is, too often, to hydrate the patient. In most febrile diseases this is good therapy, but if the child is suffering from acute renal failure the excessive administration of fluids can be fatal. Better that the physician obtain some urine and, if need be, delay the fluids until a diagnosis can be established.

In acute renal failure it is imperative that fluids be restricted. An adult needs approximately 400 cc. per day to cover for insensible loss and a child needs proportionally less—20 to 30 cc. per kilogram per day is adequate. In addition, fluids and electrolytes lost by vomiting and diarrhea should be replaced volume for volume. Under this program there should be a progressive daily weight loss or else fluid restriction has been inadequate.

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Infection.—Susceptibility to infection is markedly increased in the uremic patient. A program of isolation technique is immediately established. Ideally, a recently scrubbed private room is used, and gowns and masks are worn by medical personnel in attendance. Frequent examinations for the early detection of clinical infection must be made and, if found, treated with the antibacterial drug of choice.

It is important to realize that many of these drugs are normally eliminated by the kidneys. In the presence of renal failure, they may rapidly build up to toxic blood levels, therefore, dosage must be reduced. For example, streptomycin levels build up rapidly and persist. This may cause irreparable eight nerve damage.

Hyperkalemia.—During the anuric phase of acute renal failure, potassium retention occurs and often causes serious and rapidly fatal myocardial complications. Potassium intake is therefore completely restricted. Daily serum electrolyte determinations and electrocardiagraphic monitoring aid in the diagnosis and therapy. There are typical E.C.G. changes associated with hyperkalemia. Early potassium intoxication shows high spiking T-waves, and as the condition progresses, loss of the P-waves and spreading of the QRS complexes.

Cation exchange resins are valuable in helping to maintain safe potassium levels and can be used either orally or as retention enemas. However, these are often poorly tolerated, especially in children, and use of the artificial kidney may become necessary to correct these imbalances.

Frequently, there are other electrolytic aberrations such as an acidosis due to accumulating breakdown products. This usually does not require specific therapy. Often serum sodium levels are found to be low, but usually this is a result of over-hydration and only rarely is there a necessity for sodium administration during the anuric phase.

Caloric Intake.—By providing a maximal caloric intake in the form of carbohydrates and fat, the breakdown of the patient's body protein is diminished, and thereby the release of potassium is decreased. This also serves to slow down the formation of nitrogenous retention products and to avoid ketosis. Preferably, the calories can be administered orally in the form of ginger ale and Karo syrup, rock candy, and butter balls, but if necessary, can be given intravenously in the form of hypertonic glucose.

A progressive anemia is consistently encountered in the course of acute renal failure. This is usually well tolerated; however, it is refractory to therapy and stabilizes at a hematocrit level of 25 to 30 per cent. If transfusion becomes unavoidable, it should be given as fresh packed cells in small increments to minimize the exogenous potassium and fluid administration.

Not infrequently, the patient's condition deteriorates and even the best conservative program is inadequate and use of the artificial kidney becomes necessary. In this method, the blood is circulated outside of the body through a cellophane membrane which is in contact with a standardized bath. Dialysis takes place and the retention products, such as urea, creatinine, and metabolic acids are removed. The plasma electrolytes can be adjusted and over-hydration can also be corrected by ultrafiltration.

Recent medical literature would suggest that the indications for extra-corporeal hemodialysis are increasing, and that most of contra-indications are being overcome. As experience with the artificial kidney has increased, it has become obvious that there is virtually no need for mortality from its use, nor is there any significant morbidity when dialysis is employed properly by a well-trained team. Indeed, the attitude toward its employment is changing from one of using dialysis as a last resort, to the point where today O'Brien and Teschan have even been using daily prophylactic dialyses of patients with acute renal failure before the uremic syndrome develops, and they have reported excellent results.

Last year, the University of Michigan Medical Center was faced with an interesting case of anuria in a four-month-old infant. Conservative methods proved to be inadequate and it became apparent that some sort of dialysis was indicated; however, in view of the fact that no child this young had ever been treated with extra-corporeal hemodialysis, it was deemed that the more conservative peritoneal dialysis be tried. This was attempted on two occasions but was technically unsatisfactory because of failure of return of the dialysate from the infant's peritoneal cavity.

The child's condition progressively deteriorated and it was apparent that the only possible hope for saving the life of this infant was extra-corporeal dialysis. Two dialyses were subsequently carried out and were, from a technical and chemical viewpoint, highly successful; yet the child eventually expired.

Autopsy revealed why dialysis had failed to salvage this infant. The anuria was due to bilateral cortical

necrosis, an irreversible condition—one of the rare causes of acute renal failure.

This infant was the youngest human ever run on artificial kidney and the efficacy and safety of this modality was thereby satisfactorily demonstrated. Since that time, extra-corporeal hemodialysis has been used in even the youngest patients when indicated.

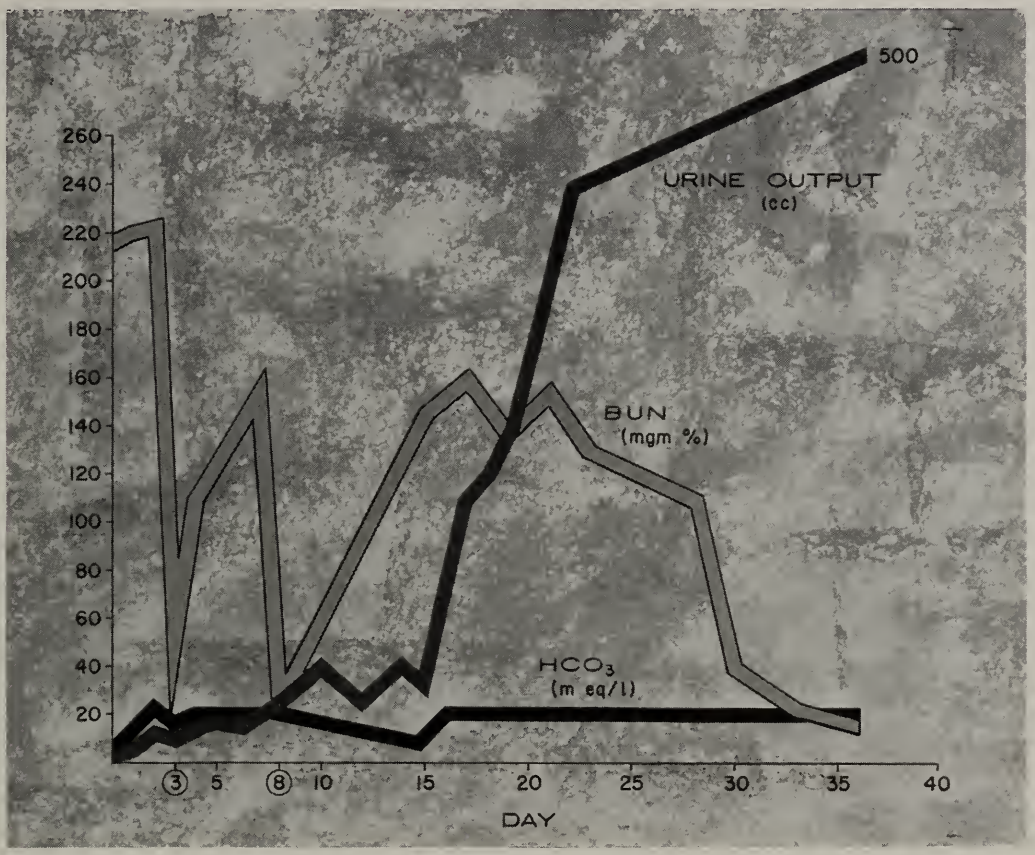


Fig. 1. Graph representing hospital course of eleven and a half month old acute renal failure patient. Note relationship of blood urea nitrogen, urinary output and serum bicarbonate to extra-corporeal hemodialysis on days three and eight.

A recent example was an eleven-and-one-half-month-old girl who was admitted with a three-day history of irritability followed by lethargy, rapid respiration, and failure to void for forty-eight hours. Two weeks prior to admission she had been seen in the Well Baby Clinic and found to be normal in all respects.

On physical examination, the child was pale and lethargic. Vital signs were normal except for rapid respiration. No abdominal masses were palpable.

Emergency blood chemistry studies revealed a blood urea nitrogen of 220 mg. per cent with associated acidosis. Three cc. of urine obtained by catherization had a 3-plus albuminuria and a specific gravity of 1.015. Blood hemoglobin was 5 gms.

During the first twenty-four hours, a total of 1016 cc. of fluid was given as whole blood and electrolyte solution. This corrected the acidosis but a 1-pound weight gain occurred and she became increasingly lethargic; she had been over-hydrated.

Intravenous pyelograms failed to demonstrate the kidneys and therefore retrograde catheterization of the ureters and pyelograms were made. These studies demonstrated that there was no obstruction. This was done under local anesthesia to avoid the added insult of general anesthesia. After observation for two to three days her condition deteriorated, and it was elected to perform hemodialysis. Because her condition was extremely critical, we were embolden to do this.

Following dialysis, the patient's general condition improved. The blood urea nitrogen fell from 222 mg. to 49 mg. per cent, but slowly elevated again over the next seven days. The urinary output remained low, averaging 15 to 20 cc. per day. With the elevation of the retention products as indicated by the blood urea nitrogen, the child's clinical condition again deteriorated; and one week later another successful dialysis was performed. Subsequently, the blood urea

nitrogen gradually fell to normal and the urinary output increased to 500-600 cc. per day.

In regard to the technique of dialysis in infants and children, numerous problems are encountered. The main concern is the actual circulatory dynamics. The majority of dialyses at the University of Michigan Medical Center are performed with the Kolff Twin Coil Kidney. This unit requires approximately 1000 cc. of blood to prime the coils and tubing; however, during the dialysis of infants, one of the coils can be excluded from the circuit, thereby reducing the necessary amount of priming blood to 500 cc. Since the child's blood volume in this case was calculated to be about 700 to 800 cc., during dialysis the ratio of blood volume of the infant to that of the coil was slightly more than one to one. Any sudden shifts in blood volume could, therefore, have a profound and deleterious effect on the circulation of the child.

In addition, the size of the infant is such that the selection of vessels to use for the inflow and outflow of blood from and to the artificial kidney becomes a problem. In the adult, the radial artery and cephalic vein at the wrist are generally used. In the infant, the greater saphenous veins at the level of the fossas ovale are selected because of their size and accessibility. Bilateral cut-downs are performed and the inflow catheter passed into the vena cava to the level of the thoracic diaphragm. The outflow catheter is passed to the level of the confluence of the common iliac veins.

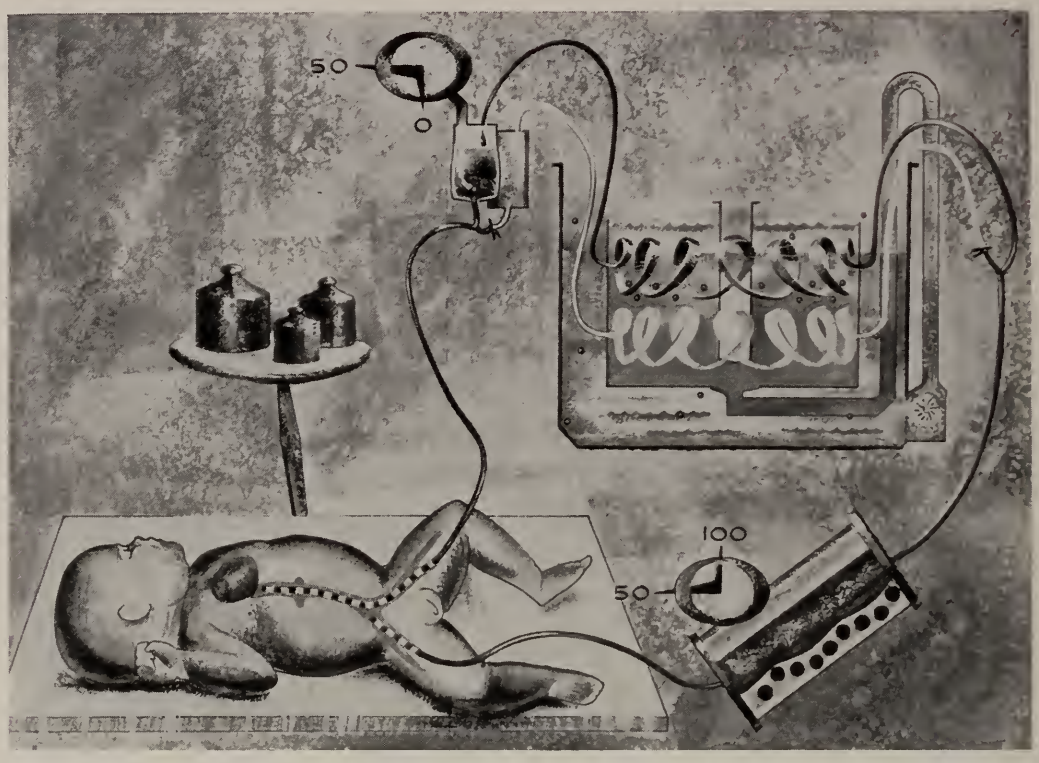


Fig. 2. Diagram of technique and circulation of extra-corporeal hemodialysis of infants. Note scale for determining constant weight, the isolation of one coil from the system, and the position of the inflow and outflow catheters. A low coil pressure is maintained ranging from 0 to 50 mm. of mercury, and blood flow ranges from 50 cc. to 100 cc. per minute.

With the child on a sensitive scale, weight is observed continuously throughout the procedure so that any sudden shifts in circulating blood volume can be immediately discovered.

The patient is given 1 mg. of heparin per kg. intravenously and 5 mg. are added to the priming blood. The dialysis is started with very low flow rate and the coil pressure is maintained from 0 to 50 mm. Hg. In the present instance, no untoward effect resulted and gradually the flow rate was increased to 80 to 90 cc. per minute. The child's blood presure, pulse, and respiration remained stable. The 100-liter normal bath was changed once during the three-hour dialysis run.

This last infant has apparently completely recovered from a period of over twenty-one days of essentially complete anuria. Unfortunately, we do not know the etiology of this child's acute tubular necrosis; however, it seems unlikely that she would have recovered if the

artificial kidney had not been employed. She left the hospital only a month ago with a blood urea nitrogen of 15 mg. per cent and appeared clinically healthy.

In conclusion, it has been demonstrated that the artificial kidney can be used with safety even in the youngest of infants when properly employed. Clinical improvement is virtually certain in all cases, so if there is any question regarding the reversibility of the underlying renal lesion, the uremic patient should be given the benefit of the dialysis. Extra-corporeal hemodialysis is not a dangerous procedure to be used as a last resort, but is rather a valuable adjunct in the management of acute renal failure in any age group.

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The Poliomyelitis Situation

Regardless of the proposed long-range advantages of oral live virus vaccine over parenteral killed virus vaccine, we have a continuing emergent situation to deal with in this State.

The results with the Salk vaccine have been good, and it is available for use. The Sabin vaccine tests well, but it is not presently available in quantity.

Pre-Salk, there were 864 cases of paralytic poliomyelitis in upstate New York in one year (1954). In 1960, there were 135 cases, almost 50 per cent of these in children under nine years of age. Sixty-one of last year's cases did not have even one injection of vaccine, and only 40 had three or more doses.

Poliomyelitis is now a disease primarily of unvaccinated babies, unvaccinated preschool children, and unvaccinated male adults. We need to concentrate on these groups, using all the lay influence we can get from voluntary agencies, the press, and other means of communication.

The hard core of the intransigent can never be reached, but the ignorant, the careless, and the indifferent can.

It is the physician's duty as guardian of the public health to do all in his power to broaden the base of poliomyelitis vaccination.

The accepted schedule for the Salk vaccine remains unchanged—two injections within a month, a third seven months later, and a fourth one year after the third.

Sigmoidoscopy in Cancer Detection

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Grand Rapids, Michigan

OUR PRESENT CONCEPT of cancer cure is based for the most part on early observation and diagnosis of the neoplastic lesion. Statistics published by the National Office of Vital Statistics[1] disclose that, when considering both sexes equally, more people die of colorectal neoplasm than from any other form of malignant disease in this country. When we consider that 65 to 75 per cent of all colorectal cancers can be felt with the finger or visualized through the sigmoidoscope it can be clearly concluded that physicians are ignoring a most important tool in cancer detection. Furthermore, it is only reasonable that considering the above statistics a physical examination of a patient that does not include a sigmoidoscopic examination must be rated as incomplete.

The reasons given why physicians do not do routine sigmoidoscopic examinations when performing a physical examination are twofold: (1) lack of proper equipment and (2) the erroneous idea that sigmoidoscopic examination is highly technical and time-consuming. These reasons when looked into are easily shown to be ill-founded and not properly based on fact. The amount of equipment needed is minimal. Actually all one needs is a standard 25-cm. sigmoidoscope with an electrical source, a suction unit, and an accessible toilet. The standard flat examing table is completely adequate and certainly more comfortable for the patient than a tilt type of table. The technique of sigmoidoscopy is simple and is not dangerous in any way if reasonable care is exercised. Complications remain nil if the following cautions are observed: (1) The scope should never be advanced without complete visualization of the bowel lumen at all times. (2) Excessive air should not be pumped into the bowel placing the bowel wall under undue tension. (3) Force should never be used in advancing the scope.

Preparing the patient for sigmoidoscopic examination requires little time or effort on the part of the patient or the physician. The patient receiving a thorough physical examination should be instructed when the appointment is made that a cleansing enema the night before and the morning of the examination should be taken. The small disposable type of Fleet's enema provides a convenient and thorough method of cleansing the bowel in the office. It is very important that the patient is thoroughly instructed about the mechanics of the sigmoidoscopic examination so that total co-operation can be obtained. The completeness of this endoscopic measure adds greatly to the total reassurance of the patient.

The attitude about and the reluctance toward complete anorectal examination could easily be changed if medical educators would place a greater emphasis on teaching medical students, interns, and resident physicians the significant place sigmoidoscopic examination plays in the total and complete examination of a patient. With more widespread interest and use of this particular tool of diagnosis, it is conceivable that the death rate from cancer could be substantially lowered.



The Author
JAMES P. MULDOON, M.D.

Reference

1. United States Department of Health, Education and Welfare, Public Health Service, National Office of Vital Statistics: Vital Statistics of the United States, 1955, Vol. II.

Doctor Muldoon is a member of the Active Staff, Ferguson-Droste-Ferguson Clinic, Grand Rapids, Michigan.

The Physician's Responsibility To the Community

The first responsibility of the physician is that of providing health information and good medical care for the people of the area in which he lives. He will also improve the stature of his profession by becoming genuinely interested in the various aspects of life in the community. This issue of THE JOURNAL is devoted largely to a series of articles which describe some of the projects already in operation in our state and we are hopeful they will be copied in other areas.

It has been said that physicians are too busy caring for patients to become actively engaged in community life. This may be true in some areas, but some of the busiest doctors I know find time to participate in some extra-curricular activity in which they not only serve the community but also their profession. Every physician, as a responsible, highly trained, and respected citizen, should take an active part in some type of activity for the improvement of the community in which he lives.

Those of us who are particularly interested in the care of older people should make every effort possible to see that proper facilities for good patient care exist in our area and that these resources are made known to those who need them most. It is surprising how often persons are found with chronic disabling illness, sitting in wheelchairs in their homes or institutions because of failure to use the many new techniques of treatment. As physicians it is our duty to keep our community informed of all the advances in medical science in order that the health of our older citizens will be maintained at the highest level possible.

Surveys have repeatedly shown that a considerable number of cases of undetected disease exist in every community and that these cases could be uncovered early if enough local publicity were given to the need of regular health appraisal examinations. I am sure local health departments would be glad to cooperate in providing screening techniques through chest x-rays, eye testing for glaucoma, and blood tests for diabetes. Cases with positive findings would then be referred to the private physician for evaluation. This procedure should only be done, of course, in lieu of a regular examination in the physician's office, which is always more desirable, but unfortunately many people never go to a physician except when they are ill. They have not been taught that regular visits to a physician are part of everyone's own health program and a very important kind of preventive medicine.

With the growing interest in Geriatrics, there has developed a renewed optimism about the medical care of the aged. Surgery is now being done with ease, which had been previously thought to be

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impossible, and has added years of comfort to many of our older patients. The improved outlook toward the psychiatric care of the mentally disturbed elderly patient is most gratifying and has prevented the final commitment of many so-called senile patients to state mental hospitals. Then, too, the efforts at rehabilitation of patients with chronic disabling illnesses have proved that our previous attitude of pessimism is no longer justified in those patients with a reasonably good potential. It is this type of knowledge that the community wants, and the physician is the logical person to disseminate this information.

In our efforts to help the older person adjust himself to the process of growing older, it is more and more apparent to some of us that some type of work is the key to a successful retirement. There are those people who seem to enjoy doing nothing, but they are certainly in the minority. Most of us need a sense of continued usefulness and an opportunity to work, if we want to. To that end, if some type of part-time work could be developed by the community for those people who want it, I am sure that some of the many illnesses growing out of loneliness, idleness, and boredom would be postponed at least until such a time when real physical disability prevented any meaningful activity. Work is an important aid in maintaining one's self-esteem and a sense of real value to the community. When these are lost, certain psychologic changes develop in the personality of the individual that we recognize as typical of the confused and senile patient. We must make an effort, therefore, to keep the older person active in the life and work of the community as long as possible. Here, again, it is the duty of the physician to inform the community of the urgent need of providing some type of work program for its older members. There is no substitute for useful activity.

If more physicians were actively engaged in some form of civic endeavor and were making a sincere effort to improve the health status of our citizenry, I am sure there would be less reason for criticism of the medical profession. At the present time, we are not held in very high esteem by a certain segment of the population. Most of the reasons given are not justified, yet we must admit some defects do exist. It seems to some of us, therefore, that the remedy lies largely in the doctor's own hands. We must use all the ingenuity we possess to remedy the defects instead of trying to convince the public that such defects do not exist.

A. Hazen Price, M.D.

Congratulations to Michigan Medicine

At this time of the year, the Annual Session of the Michigan State Medical Society is in progress. The officials and the various committees have prepared another outstanding three-day session of the Society devoted to the most recent, the most stimulating and the most comprehensive presentation of what is new in the whole field of medicine. Guest speakers have been brought to Grand Rapids from all parts of the United States and Canada. The best informed men who could be obtained have been or are being presented to the Society in the form of prepared papers, demonstrations, panels, symposia, moving pictures, and the spoken and the written word.

Each year as we attend these programs, mix with these educators and return home, we are impressed with the vastness of medical knowledge of which we as individuals can partake and marvel at, or can absorb and make part of our own ability to care for our patients. Programs and presentations this year have been well up to the standards set during the years with always the addition of some new item, the report of some new discovery or procedure. We only have to look back on a very few years to see what amazing progress the medical profession has been making each year.

New and Improved Pharmaceuticals

Well over 100 pharmaceutical and manufacturing representatives who produce the medication, materials, instruments and equipment which are being used in medicine have demonstrated their wares and have contributed to our practical education in the area of what to do for our patients after we have diagnosed their conditions. These representatives have shown us new drugs, new equipment which were unknown five or ten years ago and even two or three years ago. Ordinarily, a few new drugs are demonstrated to us each year which we can use in our treatment of patients, and many of them are rather expensive. Each pharmaceutical house, especially the larger ones, has whole scientific staffs at work doing research, trying to work out new methods, new drugs, new modifications. Occasionally, a completely new chemical is discovered after extensive searching by a staff of trained research men who have worked day in and day out for months and years before they discover one new and acceptable item.

We of the profession appreciate this situation. We appreciate the tremendous amount of work necessary, much of it commercially non-productive work. We can only imagine the amount of money tied up in the evolution of one or two pharmaceuticals.

This last year, we have had a sample—a very acute

sample—of another approach to this problem. In the past, the pharmaceutical houses have borne much of the expense of publishing this JOURNAL and others, including the *Journal of the AMA*. They pay for the advertising and for the exhibits at our Annual Session. This money must come from the sale of their products.

Just about a year ago U. S. Senator Kefauver established a committee of inquiry and investigation about drugs. He brought several of the drug firms under his investigation, giving them all the ridicule and bad publicity he could, accusing them of charging high prices for certain of their pharmaceuticals which cost very little to manufacture. His committee ignored the many millions of dollars invested in research to develop these particular products which must be repaid through their sale. He criticized their advertising. This program has been reflected upon our own JOURNAL. Beginning about a year ago, we lost more than 40 per cent of our advertising revenue. Of necessity, the size of THE JOURNAL has been curtailed, and that affects our medical authors who give us papers for publication—very good papers which are abundantly worthy of publication, many of which we have not been able to use.

This situation came upon us suddenly. We had been accepting papers with the full intention of publishing them soon—as in past years—but all at once we discovered we had manuscripts that were a year or more old, waiting to be used. The Editor and the Publication Committee are embarrassed, because these papers should be printed. We are hopeful something will happen to allow our advertising to recuperate and allow us to use the material now in our files. Some new papers are being accepted also which must be used. For some months past, papers accepted for specialty numbers have been used as promised, but the others that come through various sources, such as direct presentation, have been delayed, and many papers have been returned to the authors with the explanation that we do not have room.

Michigan Medical Service

We wish to congratulate the Michigan medical profession, as we have done for so many years, on its great contribution to the social-economic field of medicine by establishing and creating Michigan Medical Service. This work began in the early days of the great depression which most of our practitioners do not even remember. Very few people had work, and there was practically no hope. Doctors cared for their patients and hoped that they might be paid some day. Getting a patient into the hospital was almost impossible and many times the doctor had to guarantee that payment.

In 1931, a committee of the Michigan State Medical Society (The Committee on Survey of Medical Service and Health Agencies) began a study. A report was made to the House of Delegates at the 1933 annual session, consisting of 174 pages and 20 pages of appendix. Starting with this material, several groups in Wayne, Calhoun and Washtenaw Counties developed and evolved, through final action of The Council, the Michigan Medical Service.

This was a complete, absolutely new concept of paying for medical services, the result of ten years of intensive study by dedicated medical men who were not afraid to work and whose sole idea was to establish some method by which medical men could deliver and our patients could receive essential medical care. The plan was an immediate success. It grew during the years, expanding so far beyond the fondest dreams of its originators that Senator Vandenberg dubbed it a "public trust."

After its first rate adjustment, Michigan Medical Service had only one rate increase by 1955 and had built up a reserve of $8 million—almost exactly the amount needed to pay for three months' services. Then came the Governor's Commission, Labor's antagonism, the hearings before the Insurance Commissioner, the months of adverse newspaper publicity and repeated inadequate rate allowances.

Here was a corporation with three and three-quarter million subscribers paying a tremendous portion of medical and surgical services in the state, founded by inspired dreamers who knew not how well they built. Here was a public service corporation paying out almost three million dollars a month for the medical and surgical services to our subscribers. Has anybody any idea what the potential value of this organization was?

Liberalization

In about 1955 and 1956, a change in attitude developed. Our subscribers wanted more services and our doctors wanted to render more services. Some wanted a deductible plan, and some suggested that many surgical conditions could be cared for in the out-patient department of the hospital or in the doctor's office and thus save hospital beds. This was done. At that time, many of the Blue Shield organizers who had served during the development stage were still on the Board. A feeling grew that the term of membership on this Board should be interrupted, thus extending the numbers and bringing in new workers. Our subscribers began to drop gradually over the next five years.

Our financial situation also worsened. Our $8 million of reserve was dissipated, including another $2 million overdraft. In the early years, Blue Shield required its plans to build up reserve to the point of three months' payments. The Insurance Commissioner refused to allow rate adjustments which would continue this reserve. He saw to it that the reserve was

used up. The present Commissioner, about two years ago, refused to allow sufficient adjustments to rebuild the reserve—saying he did not believe in it. At the last adjustment, the Commissioner cut off the percentage needed to re-establish the reserve, but demanded that the reserve be re-established.

Poor Public Relations

The medical profession is again under attack by Labor and by the Federal Administration. In Michigan Medical Service, we have an entity of untold value, providing services for our subscribers to the amount of approximately $7 million a month. This is a remarkable and very precious public service which makes it possible for the doctors to care for their patients and for the patients to get almost unlimited services. But what is the future? Professor McNerney, in his report just rendered, made one very specific recommendation—that in Blue Cross and Blue Shield the doctors in active practice, the active hospital administrators, not be put on the governing boards. He suggests public citizens. He undoubtedly thought that corporations of the value of these two should have specially trained executives as directors and trustees.

The medical profession in Michigan developed this program which insurance experts claimed was impossible. Michigan State Medical Society members and their advisors were capable of doing the job. They are capable of continuing. We have every confidence we can find among our nearly 7,000 members enough with public spirit, dedication and knowledge who can operate these two corporations. We fear, if they are taken away from us and given to the public in general, the ethical medicine procedures and philosophy will be eliminated and we shall have just another insurance company. Another look should be taken and another leap into a constructive future.

For the past five years, the number of subscribers has been going down, the reserves have been going down, the public concept of our services has been going down and the threat to take over through the King-Anderson program has been increased.

A Job To Do

Blue Cross and Blue Shield defeated the Wagner-Murray-Dingell Bills. If they are wholeheartedly accepted by our membership and made to work, Blue Cross and Blue Shield will defeat this present threat to the private practice of medicine. This can only happen if every member of our Society makes it work. The program is liberal. Subscribers within the income limits are entitled to their services and a great many of our doctors are religiously rendering these services in strict conformity with the rules. To those subscribers over income limit, the doctor has a perfect right to make his customary charges. He should make this explanation to the patient before rendering his bill. There are extraordinary services some of our men are rendering, so intricate and new and in such amazing fields, that no insurance program ever could properly compensate for the time and the work. The whole profession should cooperate and should help make this burden easier.

Our critics are labor leaders, bureaucrats, who have absolutely no sympathy with the medical profession as is indicated by their continuous tirades against everything "medical." We can only hope this period will pass quickly and that the profession will be able to maintain its dignity and will retain its place of honor.

The liberalization program mentioned above was supposed to render more efficient care to our subscribers and also to make hospital beds available for other purposes because being a bed patient was a prerequisite to the surgical program. Constantly increasing adverse criticism due to the requested rate increases necessitated by increased costs and volumes of services has had an influence upon the growth of Blue Shield in Michigan. In 1957, there were 3,751,000 subscribers. This has gradually declined until in April, 1961, there were only 3,318,000 subscribers, with the prospect and the knowledge of many other cancellations. During this same period, the national Blue Shield program had increased from 39,619,000 to 45,328,000. These are published figures. Actually, only one other state has followed Michigan's trend. Every effort and every study is being done to reverse this trend, but all of the publicity has not helped the situation.

The McNerney report, as mentioned last month, stressed that the costs of hospital and medical care are on a definite increase. That philosophy must be accepted. It mentioned that the doctors must reverse the public opinion in some way. One item we would like to suggest is that, in all our contacts, an effort be made to separate "medical care" from the total mass of health care. Every time a report is made about the increases here and there and the new King-Anderson Bill and what it will do, social security and all the rest mention "medical care."

President Kennedy gave us a hint of his policy for the social security program. The King-Anderson Bill (HR 4222) does separate medicine from the general health program. Specifically and implicitly it excepts from the benefit all medical care except anesthesiology, pathology, physiatry, and radiology in the hospital, giving the impression that those branches of medical care will be accepted. The Bill provides that those services will be used when they are "functions of the hospital." There is no provision in the Bill to pay these medical groups direct.

The philosophy entailed in caring for the aged

(Continued on Page 1332)

AMA Clinical Meeting Offers Many Subjects

A group of Western physicians will present a study of medical aspects of American habits as a highlight of the program of the 15th annual clinical meeting of the American Medical Association, Nov. 26-30 at Denver.

William Covade, M.D., of Denver, is chairman of the section. The program will include such topics as "The Coffee Break," by E. Chester Ridgway, M.D., Cody, Wyo.; "Psycho-Stabilizers," by Jack O. Stoffel, M.D.; "Psycho-Sexual Aspects," by Bradford Murphey, M.D.; "The Pet in the House," by Francis T. Candlin, D.V.M.; "Automobile Driving," by Horace E. Campbell, M.D., and "The Cocktail Hour," by Clyde E. Stanfield, M.D. This team of doctors has been studying the various American habits to be covered in the section for some time, and the program is expected to draw wide interest among the profession.

Chemotherapy in cancer, an area in which knowledge is growing rapidly, will be another important feature of the clinical meeting program.

Much new knowledge has been gained in the last decade in the important area of antibodies and antigens. Several papers have been scheduled to report some of the new findings to the clinicians.

Many, many other subjects will be covered at this AMA clinical meeting.

* * *

AMA Makes Staff Changes

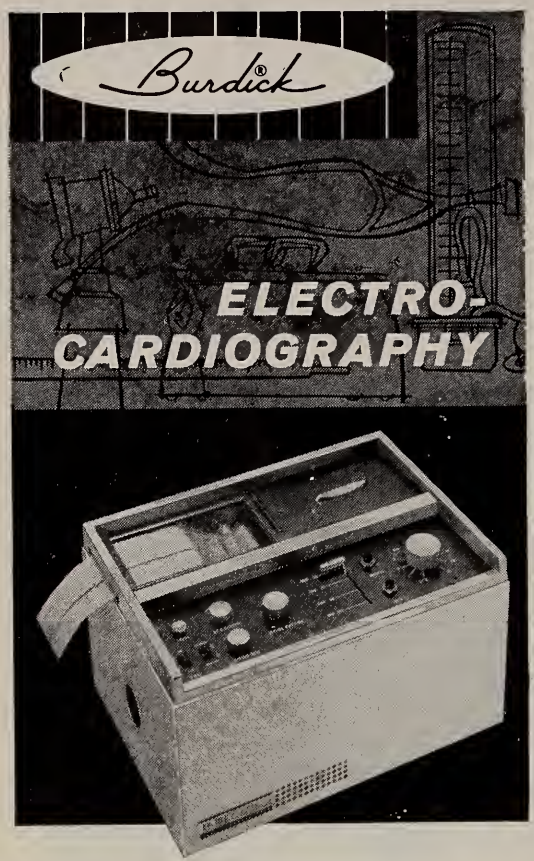
Leo E. Brown is now the assistant to the executive vice president of AMA, and James Reed, director of press relations and editor of *The AMA News*, takes over as director of the communications division.

The changes were prompted by the need for additional manpower to assist in coordinating and implementing the expanding programs of the Association.

Mr. Brown joined the AMA staff in December, 1950, as the first executive secretary of the Student American Medical Association. He became AMA public relations director in March 1951 and director of communications when that division was created in 1959.

Mr. Reed came to AMA in June, 1958, to start *The AMA News* after serving more than eight years as editor of the *Topeka* (Kan.) *Daily Capital*. He became AMA director of press relations the first of January this year, continuing his duties as editor of *The AMA News*.





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Let's Learn from Others

Leonard W. Larson, M.D., Bismarck, N. D., president of the AMA, concluded his recent testimony re HR 4222 before the House Ways and Means Committee of the Congress in these words:

"The American people have been called upon to sacrifice to build up the strength of the nation so that we can meet the rising peril of communism. But we don't believe that America can be strengthened by sacrificing the best system of medical care in the world. We don't believe America can be strengthened by copying medical systems under which one foreign country after another has lost leadership in the science and arts of medicine. We don't believe the strength of this nation lies in the direction of substituting medical failure for medical success."

Michigan Medical Service

A Job to Do

(Continued from Page 1328)

through social security, in our opinion, is wrong. It is an entering wedge for socialized medicine. The sponsors have been very careful to eliminate medicine in writing this Bill, but once passed, a very simple amendment can eliminate this exception and we are all in it. In contacts with our newspapers and with our publicity channels, it would seem wise to impress upon the public that when referring to the increased health care, and the expanding cost, stress be placed upon the fact that the purely medical care included has not increased measurably and only covers 27 cents out of the so-called "medical dollar"—the health dollar. The health dollar now covers mostly hospitals and nursing by the very definitions of the King-Anderson Bill.

Special Number

We wish to express our appreciation to Doctors Cortopassi, Crossen, and Price for their assistance in assembling the material for the Otolaryngology, the Ophthalmology, and the Aging numbers. They have secured very well-prepared and well-thought-out papers, and we again thank them.

Seat Belts

Recognizing the safety value of seat belts, The University of Michigan has started installing seat belts on all new automobiles when purchased.

Use MSMS Members In MAP TV Series

"Decision: The Moment of Truth," televised series providing information about health organizations and depicting the activities of the member professions of MAP, has proven to be a popular Sunday morning program in Michigan.

Designed to point up the decisions that the professional man must make in the practice of his profession, "Decision" features outstanding individuals in the professions, lay-persons with special knowledge in related fields and leaders associated with the Michigan Health Council, co-sponsor of the program.

To date several MSMS members have appeared on the program. Physicians and subjects include:

H. H. Stryker, M.D., Kalamazoo—"Orthopedics"
Otto K. Engelke, M.D., Ann Arbor, President, MSMS, and Harry B. Zemmer, M.D., Lapeer—"What MHC Is"
Robert H. Trimby, M.D., Lansing—"Baby Emergencies"
Joseph Schaeffer, M.D., Detroit—"Rehabilitation"
Sidney E. Chapin, M.D., Dearborn, President, MHC—"MHC State Conference"
Kenneth H. Johnson, M.D., Lansing, Past-President, MSMS—"The MSMS President's Program"
Richard E. Straith, M.D., Detroit—"Plastic Surgery"
George Lowrey, M.D., Ann Arbor; Johan Eliot, M.D., Ann Arbor—"Baby Safety Tips"
T. S. Conover, M.D., Flint; Richard C. Bates, M.D., Lansing—"Alcoholism"
William Hubbard, M.D., dean, U. of M. Medical School—"Health Career Exhibit"

Informal and informative, "Decision" gives the viewer the illusion that he is being accorded the privilege of a look behind a door marked "private" to learn first-hand what the professional man is doing, how he does it and why he does it.

Visual aids seldom seen by the lay-person are used and the general effect is like listening in on a private conversation between experts who are discussing "trade secrets."

Scripts are written by John B. Kantner, MHC director of Professional Replacement. Hugh W. Brenneman, MSMS Public Relations Director and Executive Director of MAP, narrates the 15-minute programs.

It is shown each Sunday morning from 9:00 to 9:15 a.m. over WJBK-TV, Channel 2, Detroit. A complete list of more than 30 programs can be secured by writing MAP Executive offices, 120 W. Saginaw, E. Lansing.

* * *

Schedule MAP Congress At Michigan State

The time and place chosen by the Board of Directors of MAP for the third annual CONGRESS OF THE PROFESSIONS, February 9 and 10, 1962, East Lansing, was selected by the members who replied to a survey mailed them earlier this year.



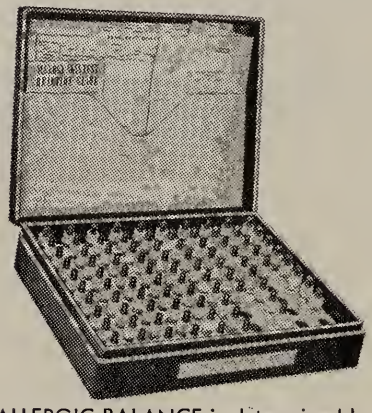
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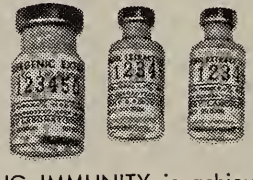
How to restore your patient's allergic balance the "classic" way . . . use specific desensitization for

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Lansing was the number one choice of location of those replying, with the majority specifying that a Congress devoted to professionalism should convene at an academic center such as Kellogg Center, MSU. Winter was the preferred season and most members asked for a one and one-half day conference with programs directed to mutual aims and problems. The 1961 theme, "Great Thoughts, Great Accomplishments and Great Challenges," was a popular choice for program material.

The Congress Planning Committee is already hard at work trying to incorporate as many of the recommendations of the members as possible to fit into the day and a half program. Tentative plans include a meeting to further consider the organizational structure of the American Association of the Professions, incorporated last summer. Leaders of national professional associations and others interested in forming state associations of the professions in other states are being invited.

Show Beaumont Plaque At Annual Session Exhibit

The new bas-relief plaque of William Beaumont, M.D., was exhibited at the 1961 MSMS Annual Session. The plaque is being stored now at MSMS and will be featured next summer at the Beaumont Memorial at Mackinac Island.

The plaque, done by Artist Marshall Fredericks, credits the Mackinac Island doctor as "Pioneer in Gastric Physiology."

The original plaque is at the Beaumont Hospital in Royal Oak.

The copy for Mackinac Island was possible through the generosity of Herman Scarney, M.D., Detroit, and three Bloomfield Hills men—Howard Barker, M.D., Mr. Lawrence S. King, and Mr. Irving Babcock.

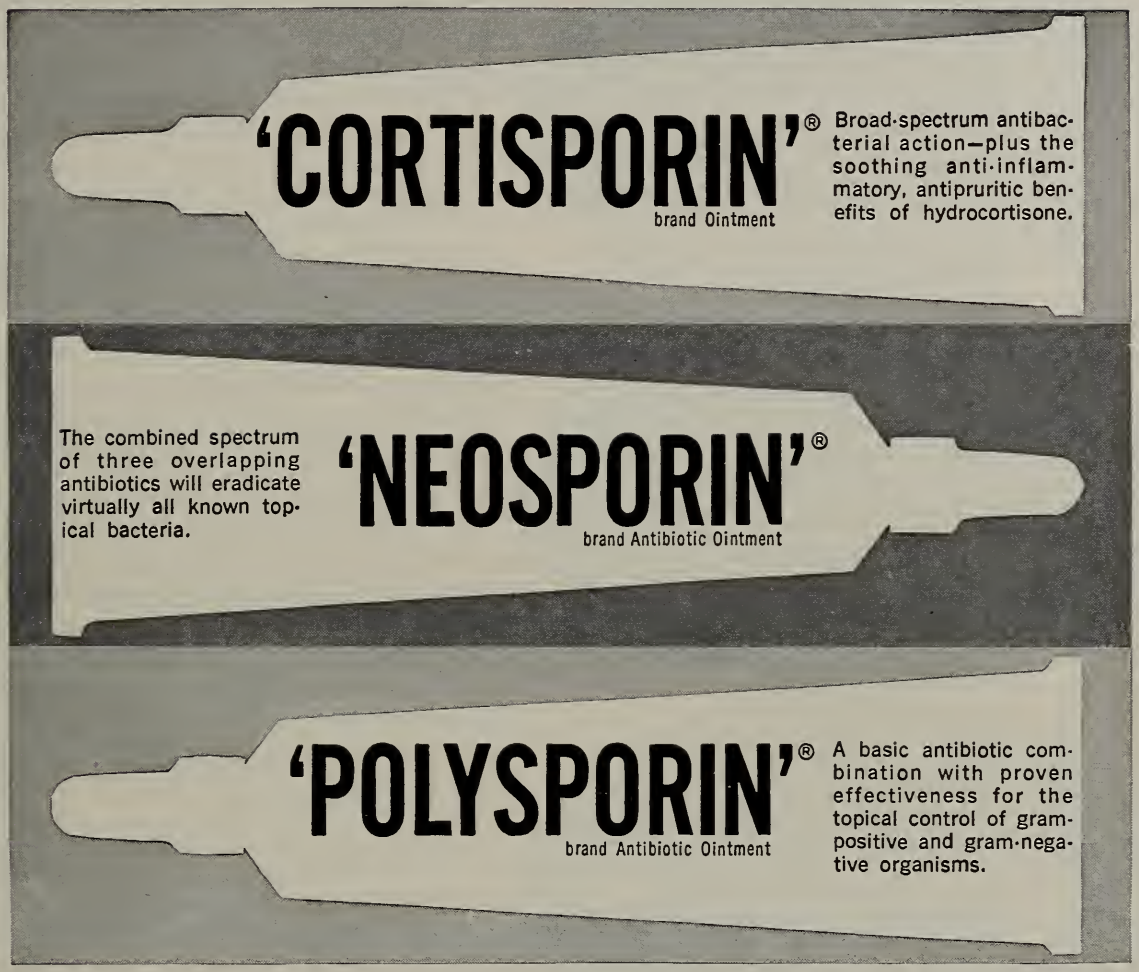
Find Tuberculosis Decline

A steady 10-year decline in the number of new cases of active tuberculosis discovered among Veterans Administration patients admitted for treatment of other diseases has been reported by the Veterans Administration.

The rate in the Veterans Administration tuberculosis case-finding program, which excludes hospital patients admitted for tuberculosis, has declined from 58 per 10,000 in 1950 to 10 per 10,000 in 1960.

"I recommend that a jobs-for-the-aged campaign and program be initiated on a nation-wide basis—in every city, town and community across the land."—DAVID B. ALLMAN, M.D., Atlantic City, N. J., Past-President of The American Medical Association.

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Say you saw it in the Journal of the Michigan State Medical Society

MICHIGAN DEPARTMENT OF HEALTH
ALBERT E. HEUSTIS M.D., State Health Commissioner

To Discontinue X-Raying Under Thirty Years of Age

Policy regarding the age of persons to be x-rayed by mobile screening x-ray units has been changed so that no one under the age of thirty will be x-rayed in mass screening programs. Previously, the minimum age was twenty-one.

The minimum age has been raised to thirty because the yield of tuberculosis cases found by mobile x-ray in those under thirty is so slight. Actually, better than 92 per cent of persons discovered to have active tuberculosis by use of the mobile x-ray are over thirty years of age. Equally significant is the fact that 98 per cent of the heart abnormalities and 91 per cent of the suspected lung tumors discovered by mobile x-ray units occur in persons over thirty.

Plans are being developed so that persons under thirty will be tuberculin tested at the same time those thirty or more years old are being x-rayed. Those with positive tuberculin tests will be notified to report for a chest x-ray and other tests necessary to confirm or rule out tuberculosis.

Latest figures indicate that approximately 20 per cent of the people of Michigan are tuberculin reactors. In tuberculin surveys of school children, carried out on a statewide basis, 2.5 per cent were found to be reactors to the test. It is from this presently infected group that most of our future cases of active disease will come so it is extremely important that the infected individuals be identified and kept under close observation.

The thirty-year-old limit is effective at once in areas where mobile x-ray units have not been scheduled. Where they have already been scheduled and announced, with publicity materials printed, persons twenty-one and over will still be x-rayed.

Venereal Disease Drug Distribution

The Michigan Department of Health has been supplying aureomycin, 250 mg. capsules, for the treatment of penicillin-sensitive cases of *syphilis*. In the future, erythromycin will be substituted for aureomycin, primarily because it has been shown that there are fewer side effects from erythromycin. The dosage and treatment plan is the same as with aureomycin, outlined on the treatment schedule recommended by the Venereal Disease Control Committee of the Michigan State Medical Society.

Erythromycin is not supplied for the treatment of other venereal diseases. It is required that the request for this drug be accompanied by a case report (V-76) with a brief statement from the physician stating that the patient is penicillin-sensitive, the amount of previous therapy, and the reason he believes the patient is hypersensitive to penicillin.

Requests should be made to your local health department. Because of the high cost of this drug, it cannot be stockpiled at local health departments but will be replaced upon request on an individual case basis under the criteria outlined above.

If you practice in an area not served by a full-time local health department, the drug is available upon request to the Division of Tuberculosis and Adult Health, Michigan Department of Health.

Tetanus in Michigan

One of the most severe attacks of tetanus ever treated at The University of Michigan Medical Center was a thirteen-year-old boy from Monroe, Michigan.

Jack Burns was admitted to University Hospital last June with classic symptoms of "lockjaw," the dread tetanus. Once quite common, the infection is now rarely seen because of the widespread use of immunization. The boy had driven a splinter into his foot seven days earlier. He had never been immunized, and the disease took hold. For the next five weeks his body was twisted with painful muscle spasms. Death from asphyxia or utter physical exhaustion was always near.

Surgeons performed a tracheotomy to help him breathe. They removed the offending splinter. Anesthesiologists gave massive doses of muscle-relaxant drugs to counteract the violent spasms. A pediatrician, like a field general, watched the hourly progress of the disease and enlisted the help of other specialists to meet each emergency. Private duty nurses were in constant attendance.

An extensive amount of hospital equipment was brought into play: heat exchanger, pressure mattress, two respirators and other items. At one point the circuits became so overloaded University electricians had to string emergency power lines to the boy's bedside to operate all the apparatus.

Only rare cases of tetanus have lasted more than four weeks. Jack's last spasm—a comparatively minor one—occurred on August 2, five weeks after the onset of the disease.

The Michigan Department of Health reports thirty-two cases of tetanus over the past five years, seventeen of them fatal.

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For example, extensive studies are now being carried out in organic synthesis, vaccines, and radioactive isotopes. Some of these pharmaceuticals and biologicals are presently undergoing clinical trials in this country.

One research project nearing completion is a measles vaccine, now undergoing extensive U. S. clinical trial. Another preparation, soon to be available, is a progestational agent which gives promise of offering distinct advantages over those presently available. A true progestin, it will have wide application in female disturbances without androgenic, estrogenic, or corticosteroid side effects.

Philips Roxane has acquired affiliates throughout the United States, where research and development in human, animal and plant medicines are being greatly extended through their production facilities and sales organizations.

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PROGRESS IN RESEARCH FOR MEDICINE

Pathology Comment

These items are provided by the Michigan Pathological Society

Macroglobulinemia

Macroglobulins are most frequently described in the clinical syndrome known as "macroglobulinemia" and delineated by Waldenström in 1948. Characteristic features of this condition, which primarily affects elderly men, are:

Large amounts of serum protein which sediment rapidly in the ultra-centrifuge.

Weakness and dyspnea of insidious onset.

Hemorrhagic episodes, especially epistaxis.

Visual disturbances associated with hemorrhagic retinitis.

Normochromic anemia.

Lymphadenopathy.

Splenomegaly and hepatomegaly.

High sedimentation rate.

Relative lymphocytosis and lymphocytic infiltration of bone marrow.

Other diseases may have macroglobulins

The molecular weight of this unusual protein varies from 400,000 to 1 million or more. A presumptive test for macroglobulins is the distilled water test, or "Sia water test." Unfortunately false negative results sometimes occur. Definitive diagnosis is made by ultracentrifugation of the serum. For hospitals not having an ultracentrifuge, examination of serum by starch-gel electrophoresis with and without 2-mercaptoethanol has been proposed as a simple procedure for detecting macroglobulinemia.[1]

The urine in classical cases of macroglobulinemia is normal; the bone marrow commonly shows plasma cell hyperplasia and an increase in lymphocytes and mast cells. Hemorrhagic phenomena may occur without demonstrable alteration in platelets or clotting factors. Electrophoretically the peak is usually in the gamma globulins, less often in beta globulins. In addition to the condition described by Waldenström, macroglobulins are also found occasionally in congenital syphilis, hepatic cirrhosis, nephrosis, multiple myeloma and cancer. In these diseases, however, immunologic studies have shown that the high molecular weight proteins found differ antigenically from those found in Waldenström's disease.

Coagulation defects which have been reported with macroglobulinemia include delayed clotting, slightly prolonged prothrombin time, deficiency of fibrinogen conversion accelerator factor and intereference with the conversion of fibrinogen to fibrin. There rarely may be poor prothrombin consumption and prolonged bleeding and clotting time.

Reference

1. Butler, E. A., Flynn, F. V., Harris, H. and Robson, E. B.: The laboratory diagnosis of macroglobulinemia. Lancet, 7197:289 (Aug. 5) 1961.

New General Anesthetic

A highly successful new general anesthetic has been administered to more than 300 patients at The University of Michigan Medical Center. Used for a variety of short-lasting operations at University Hospital, the drug is reported to leave patients free of dizziness, nausea and other after effects. It is especially valuable for children, but has been used successfully on patients of all ages.

Called "G-29," the drug is a milky odorless oil which will completely anesthetize a patient in 15 seconds. It is given in a single intravenous injection, usually in the arm. University of Michigan doctors say the length of time the patient is anesthetized can be controlled with great precision by varying the amount of G-29 injected. Two teaspoonsful will anesthetize a patient for about eight minutes. Recovery is prompt. The patient suffers no hangover, depression or nausea often experienced with other general anesthetics.

The University of Michigan is one of two major medical centers in the United States known to be employing G-29. The other is Duke University. The University work is being co-ordinated by Dr. Gunter Corssen, assistant professor of anesthesiology, who last fall visited the Swiss laboratories where the drug was prepared. M. J. Thuillier, a French chemist, developed G-29 and first tested it on laboratory animals.

Dr. Corssen presented a scientific exhibit on the drug at the American Medical Association annual meeting in New York City, in June.

Detroit Woman Full Colonel

One of the first "lady doctors" to be admitted to the Army during World War II became the first woman ever to wear the eagles of a full Colonel in the Army Medical Corps, in a recent ceremony at Brooke Army Medical Center.

Colonel Clara Raven, pathologist, is Chief of the Laboratory Service of the 323rd General Hospital, a U.S. Army Reserve unit from Detroit.



The unit was at the Medical Field Service School for its annual two weeks of active duty for training this fall, when the promotion was made. Colonel Raven was one of the first six of about 75 women physicians admitted to the Army in July 1943, and served for four years. She has continued her reserve affiliation since then.

She holds BA and MS degrees in bacteriology from the University of Michigan, with considerable foreign language. This led to a job with the American Medical Association to translate and abstract Russian, German, Spanish, French, and Italian medical literature. Subsequently she obtained her medical degree from Northwestern University School of Medicine.

Since her return to civilian life in 1958, Colonel Raven became deputy medical examiner, first for Los Angeles, Calif., and in November 1959 for Wayne County. She knows of no other woman in a similar capacity.

MEDICAL SERVICE CORPS OFFICERS—Public Law 87-142 amends Section 3579, title 10, United States Code; provides permissive authority for officers of the Medical Service Corps command of other troops than the Medical Service Corps. Since the establishment of the Corps in 1947, Medical Service Corps officers have been assigned in increasing numbers to branch immaterial duties. These assignments cover such fields as research and development, supply, intelligence, Military Assistance Advisory Groups, military missions, and Army aviation, as well as the Army General Staff. In addition, since the establishment of the Logistics Officer Program by the Department of the Army, certain officers of the Medical Service Corps have been approved for participation as logistics officers, and it is anticipated that many others will continue to be nominated for this important career field.



BUILDINGS UNDER WAY—Work is progressing on three construction projects totalling $4,050,000 at the University of Michigan Medical Center. Involved is the expansion of the physical medicine department and modernization of central services in University Hospital, a joint project costing $1,800,000; erection of the $1,750,000 Kresge Hearing Research Institute attached to the southeast end of the present Kresge Building; and creation of a $500,000 Clinical Research Unit on the ground floor of the hospital. The greatest amount of work involves interior structures at University Hospital to create modern facilities for patient care, teaching and research. The work began in August.

* * *

TBA HONORS PHYSICIAN—The service of John W. Towey, M.D., in his efforts for tuberculosis control were commemorated recently at a public ceremony at Powers-Spalding High School by Theodore Werle, executive secretary emeritus of the Michigan Tuberculosis Association. A portrait of Doctor Towey, himself a victim of tuberculosis while a young practicing doctor in 1919, was presented to the Pinecrest Medicare Facility at Powers-Spalding Lions Club which sponsored the painting.

* * *

MICHIGAN COURSES—The American Diabetes Association will conduct its tenth postgraduate course "Diabetes in Review: Clinical Conference," in January in Detroit and Ann Arbor. The sessions, January 17, 18, and 19, will be at the Statler-Hilton in Detroit. The lectures on January 18 are scheduled at the University of Michigan. The course is being offered in cooperation with the University of Michigan Medical School, Wayne State University College of Medicine, Wayne Medical Society, and the Michigan Diabetes Association. Frank S. Perkin, M.D., Detroit, is chairman of the local arrangements committee. For further information, write to American Diabetes Association, 1 East 45th Street, New York 17, New York.

* * *

ANNOUNCE EXAMS—The American Board of Obstetrics and Gynecology will hold the next scheduled examination (Part I), written, in various cities January 5, 1962. Current Bulletins may be obtained by writing to: Robert L. Faulkner, M.D., Executive Secretary and Treasurer, 2105 Adelbert Road, Cleveland 6, Ohio.

* * *

TB X-RAYS—By this Fall, the Michigan Department of Health expects to be x-raying only persons 30 years old and over with their mobile x-ray units. The minimum age is being raised from 21 because it has been found that 90 per cent of the persons discovered to have active tuberculosis are over 30. Plans are being developed to allow persons under 30 to be skin tested at the same time that older people are being x-rayed by the mobile units. Those with positive reactions will be notified to have an x-ray and other tests.

* * *

U-M EYE BANK—The University of Michigan "eye bank" has set a goal of 20,000 pledges to help insure a continuing supply of eyes for persons with corneal blindness. Since "The Michigan Eye Collection Center" was established

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ARLIDIN IMPROVES HEARING[3]
ARLIDIN IMPROVES HEARING[4]

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1 "significant hearing improvement" occurred with Arlidin in 32 of 75 patients with recent onset hearing impairment due to labyrinthine artery ischemia.
Rubin, W. and Anderson, J. R.: Angiology 9:256, 1958.

3 Arlidin "appears to be one of the most satisfactory [vasodilators], having the advantages of minimal side effects, being well tolerated and possessing a sustained action" in improving circulation of the inner ear.
Seymour, J. C.: Laryngology & Otology 74:133, 1960.

in 1957 at the University, the eye bank has received donations of 166 eyes. Of these, 103 were used for corneal transplants performed at University Hospital. The remainder were used for operations in Detroit, Flint and Owosso, and for research in perfecting the techniques of transplantation.

* * *

NUTRITION PROJECT—The University of Michigan School of Public Health has received a five-year training grant to expand the teaching program in public health nutrition by creating a specialty area under the direction of a physician. The University is seeking a distinguished teacher with a substantial academic background in this field.

* * *

M.D. LOCATIONS—Placed by Michigan Health Council in July and August: George J. Hoekstra, M.D., Parchment; Lloyd S. Anderson, M.D., Hancock; Earle Stine, Jr., M.D., Pigeon; Robert C. Hulse, M.D., Munising; Jack R. Inyart, M.D., Mancelona; Adolfo M. Chipoco, M.D., Detroit; W. Gene Schroeder, M.D., Ishpeming; John L. London, M.D., Muskegon Heights.

Assisted by Michigan Health Council in July and August: Joseph E. Kincaid, M.D., Kalamazoo; Leon D. Thomas, M.D., Detroit; Hans A. Beyer, M.D., Royal Oak; Marlin P. Krenz, M.D., Muskegon; Robert C. Mahaney, M.D., Holland; John R. Spengler, M.D., Petoskey; David R. McCubbrey, M.D., Plymouth; James N. Kaufman, M.D., Allegan; Gerry L. Mayer, M.D., Ludington; Thomas J. Miller, Jr., M.D., Mason; John M. Miller, M.D., Port Huron; L. R. Mannausa, M.D., Port Huron; James E. Waun, M.D., Big Rapids; David L. Jones, M.D., Bad Axe; Veldora C. Yesko, M.D., Detroit; Carlos F. Gonzales, M.D., St. Clair; Robert A. Anderson, M.D., Cadillac; Eldon D. Keeney, M.D., Holly.

* * *

HURRICANE CARLA—Austin Smith, M.D., President American Pharmaceutical Association, after a canvas, reports:

"Nearly 40 firms who responded to our request for information and who account for most of the prescription drug production in the United States have undertaken to replace without charge damaged and destroyed pharmacy stocks in the hurricane area. Most of these firms have stated that such replacements apply to those stocks which are uninsured. The method of carrying out these activities varies somewhat according to the resources and personnel of each firm. Those who maintain or are able to furnish field representatives in the storm area instruct these men to make personal observations and to arrange for stock replacements. Others accept claims at their home offices and administer them accordingly."

* * *

SYMPOSIUM ON TRAUMA—The Ninth Annual Symposium on Trauma by the Detroit Chapter of the Michigan Committee on Trauma, American College of Surgeons, will be held on Wednesday, December 6, 1961, at the Wayne County Medical Society Headquarters in Detroit,

2

vascular insufficiency of the labyrinth is an important etiologic factor in sudden perceptive deafness . . . "vasodilators [Arlidin] are of considerable value."

Wilmot, T. J. and Seymour, J. C.: Lancet 1:1098, 1960.

4

early cases of sudden perceptive deafness should be treated by immediate stellate block "supplemented by the most effective vasodilator drug [Arlidin] . . . energetic measures to retain blood supply to the inner ear are imperative."

Wilmot, T. J.: J. Laryngology & Otology 73:466, 1959.

in impaired hearing, tinnitus, vertigo . . .

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Clinical benefit in approximately 50% of cases of recent onset hearing loss treated with adequate vasodilator and other supportive therapy is also reported by Sheehy.

Sheehy, J. L.: Laryngoscope 70:885, 1960.

CAUTION: Like any effective peripheral vasodilator, Arlidin should be used with caution in the presence of recent myocardial lesions, severe angina pectoris and thyrotoxicosis. There are no known contraindications to its use. Complete detailed literature available to physicians.

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Michigan. This is a day-long session. Wayne W. Glas, M.D., is Chairman of the Program Committee. For further information and reservations, please contact Wayne W. Glas, M.D., Department of Surgery, Wayne County General Hospital, Eloise, Michigan.

* * *

MEDICAL MEETINGS, USA

Fifteenth Annual Postgraduate Assembly, San Diego County General Hospital, Wednesday, November 1, and Thursday, November 2, 1961, County Hospital, San Diego, California. James E. Sandell, M.D. c/o San Diego County General Hospital, San Diego 3, California.

Fifth Annual Symposium on Diabetes, November 10, Passavant Memorial Hospital, Chicago. Chicago Diabetes Association, 620 North Michigan Avenue, Chicago, Ill.

Gerontological Society, November 10-12, Pittsburgh, Pennsylvania. Robert W. Kleemeier, M.D., Washington University, St. Louis 30, Secretary.

American Association of Public Health Physicians, November 13-17, Detroit. J. M. Bistowish, M.D., P.O. Box 1568, Tallahassee, Fla., Secretary-Treasurer.

American Public Health Association, November 13-17, Cobo Hall, Detroit. Berwyn F. Mattison, M.D., 1790 Broadway, New York 19, Executive Director.

American Psychiatric Association, November 16-18, Hotel Schroeder, Milwaukee. Miss Joan D. McGucken, 756 N. Milwaukee St., Milwaukee 2, Administrative Assistant.

Radiological Society of North America, November 26-December 1, Palmer House, Chicago. Mr. Maurice D. Frazer, 3145 O Street, Lincoln, Neb., Secretary.

American Medical Association, Clinical Meeting, November 27-30, Denver. F. J. L. Blasingame, M.D., 535 N. Dearborn St., Chicago 10, Executive Vice-President.

American Academy of Dermatology and Syphilology, December 2-7, Palmer House, Chicago. Robert R. Kierland, M.D., Mayo Clinic, Rochester, Minn., Secretary-Treasurer.

American Academy of Orthopaedic Surgeons, January 27-February 1, 1962, Palmer House, Chicago. Mr. John K. Hart, 29 E. Madison St., Room 910, Chicago 2, Executive Secretary.

"Conceptual Advance in Immunology and Oncology—Fundamental Cancer Research." March 1, 2, 3, 1962, Texas Medical Center, Houston.

Department of Otolaryngology, University of Illinois College of Medicine, "Postgraduate course in Laryngology and Bronchoesophagology," April 2 through 14, 1962.



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IN MEMORIAM

HENRY P. GREENE, M.D., forty-three, Muskegon physician, died August 18, 1961. A native of Miami, Florida, Doctor Green received his M.D. degree from Meharry Medical College at Nashville, Tennessee.

Doctor Greene interned at Homer Phillip Hospital, St. Louis, Missouri, and began his medical practice in Muskegon in 1946.

KENNETH M. McCOLL, M.D., sixty-five, Detroit physician, died August 13, 1961.

A native of Detroit, Doctor McColl was an alumnus of Detroit University School, University of Michigan School of Literature and the University of Michigan Medical School. He was a former head of the medical staffs of Cottage and Eastside General Hospitals and a member of Harper Hospital. He was active in the organization of local hospital postgraduate educational programs. He was a member of numerous medical societies and the Detroit Boat Club.

BURTON M. MITCHELL, M.D., seventy-one, Pontiac physician, died August 6, 1961.

Doctor Mitchell was a member and past president of the Oakland County Medical Society, and a retired member of the Michigan State Medical Society.

He had practiced in Pontiac for forty-two years and was a former Oakland County deputy coroner. A native of Ontario, Doctor Mitchell was graduated from the Detroit College of Medicine in 1916.

He was a life member of Pontiac Elks Lodge No. 810 and Roosevelt Lodge No. 510, F&AM in Pontiac.

WALDEMAR B. MITCHELL, M.D., sixty-five, Grand Rapids physician and surgeon, died by accidental electrocution, August 18, 1961.

Doctor Mitchell had retired three weeks before to Elk Rapids. Born in Elk Rapids, he attended Ypsilanti Normal College (now Eastern Michigan University) and Albion College. After graduation from Albion College, he taught and later was principal at Onaway High School. He was graduated from the University of Michigan School of Medicine in 1926, when he began his practice in Grand Rapids.

Doctor Mitchell was on the staff of Butterworth, Blodgett and St. Mary's Hospitals, and was a past president of the Kent County Medical Society.

JOSEPH C. PONTON, M.D., sixty-one, Mason physician since 1930, died July 11, 1961.

Doctor Ponton was graduated from the University of Michigan School of Medicine in 1930, and served his internship at St. Lawrence Hospital, Lansing.

Memberships included the Galens honorary medical association, Pi Kappa Alpha fraternity honorary. He was active in the American Legion and Masonic orders.

He received the Croix de Guerre for service in France during World War I.



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LAWRENCE REYNOLDS, M.D., seventy-two, nationally-known Detroit radiologist, died August 17, 1961.



Doctor Reynolds was chief of staff, chairman of the executive committee and chief of the radiology department of Harper Hospital.

In association with several other physicians, Dr. Reynolds operated four laboratories in the Detroit area.

Doctor Reynolds, a professor of radiology at Wayne State University, was awarded an honorary degree by Wayne in 1956 for his research. His alma mater, the University of Alabama, also gave him an honorary doctorate.

Doctor Reynolds began practicing medicine in Detroit in 1922 after teaching radiology at Harvard University and Johns Hopkins University Medical School, from which he was graduated in 1916.

Among his nonmedical activities was a term as president of the Detroit Public Library Commission. Doctor Reynolds was an avid book collector, and his library contained a collection of rare medical books.

At the time of his death, Doctor Reynolds was Editor of the *American Journal of Roentgenology, Radium Therapy and Nuclear Medicine.*

He was a member of several professional medical societies and a past president of the Detroit Roentgen Ray and Radium Society. He also was an honorary member of roentgen ray societies in Germany, Italy and Colombia.

JOHN W. RIGTERINK, M.D., ninety-one, Grand Rapids physician for sixty years, died August 26, 1961.

Doctor Rigterink received a Bachelor of Science degree from the former Michigan Agricultural College in 1893 and graduated from the University of Michigan Medical School in 1901, coming to Grand Rapids in 1918.

Doctor Rigterink was a past president of the Kent County Medical Society and a life member of the Michigan State Medical Society. He was a member of the resident staffs of Blodgett, Butterworth and St. Mary's Hospitals.

GEORGE H. RUGGY, M.D., fifty, Grand Rapids physician, died August 19, 1961.

Doctor Ruggy was a former instructor in medicine at Ohio State University, who came to Grand Rapids with his wife, LeMoyne, also a physician, about ten years ago. Mrs. Ruggy died three years ago in a fire at their home.

RICHARD B. SEARS, M.D., sixty-four, Muskegon County health officer since 1938, died August 24, 1961.

A native of Grand Rapids, Doctor Sears attended the University of Michigan, from which he held degrees of Doctor of Medicine and Public Health.

A specialist in the control of communicable disease, Doctor Sears served early in his medical career as a epidemiologist for the State Health Department. He maintained a practice in Grand Rapids for twelve years.

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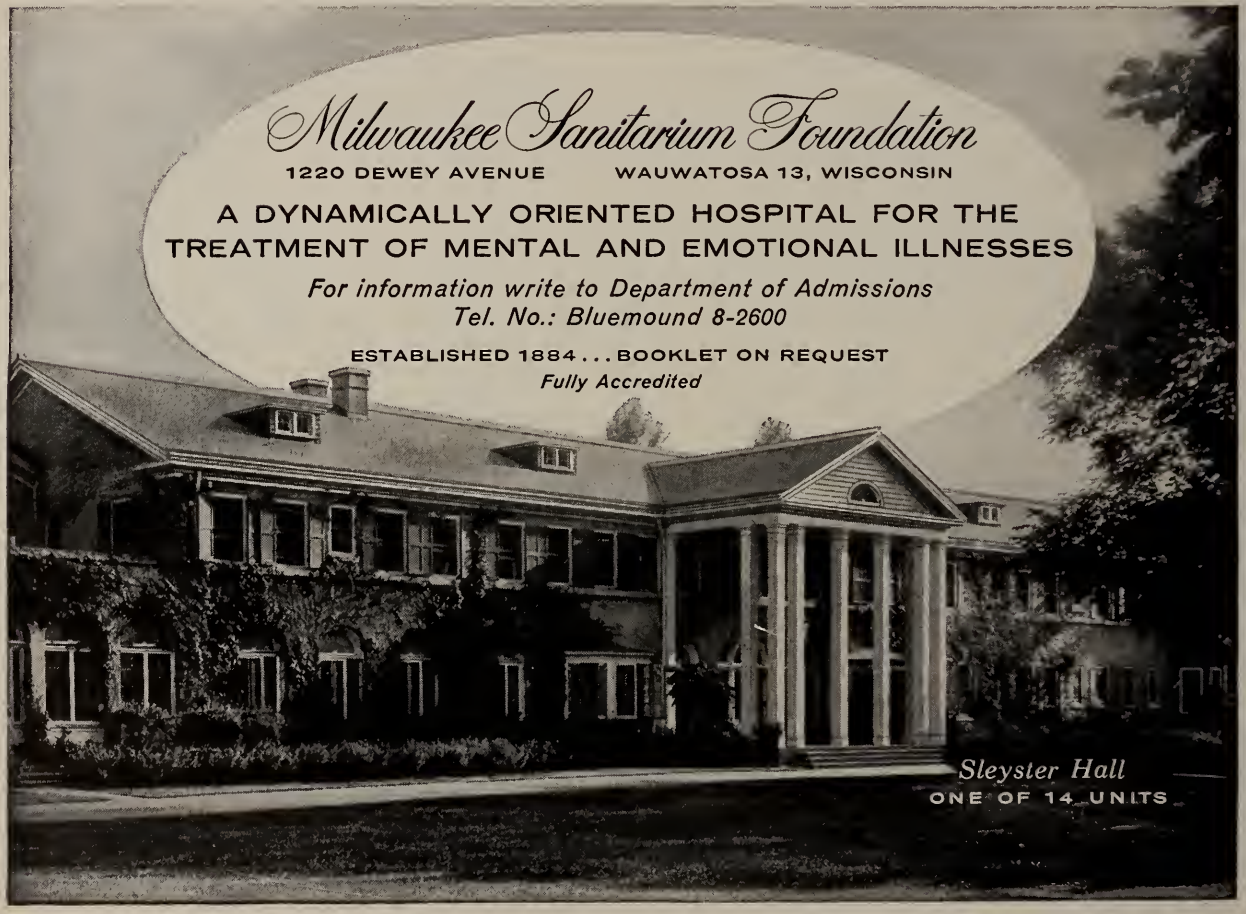
HAROLD W. WOUGHTER, M.D., fifty-four, Flint orthopedic surgeon, died August 16, 1961.

Doctor Woughter had resided in Flint since 1929. He received his M.D. degree in 1932 from the University of Michigan and served as assistant chief surgeon for Chevrolet from 1934 to 1939. He was a fellow of the American College of Surgeons and a member of several medical organizations. He took office as president of the Flint Academy of Surgery last December.

Osler Philosophy

Though little, the master word looms large in meaning. It is the "open sesame" to every portal, the great equalizer, the philosopher's stone which transmutes all base metal of humanity into gold. The stupid it will make bright, the bright brilliant, and the brilliant steady.

To youth it brings hope, to the middle-aged confidence, to the aged repose. It is directly responsible for all advances in medicine during the past 25 years. Not only has it been the touchstone of progress, but it is the measure of success in everyday life. And the master word is **work.**—WILLIAM OSLER, M.D., 1848-1919.



Michigan Authors

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Benjamin Schwimmer, M.D., Norman D. Henderson, M.D., and **B. H. Olson, Ph.D.,** Lansing, "Treatment of Acute Gonorrhea in Males with Synnematin B," *Public Health Reports,* July, 1961.

J. H. Shaffer, M.D., Detroit, "Stinging Insects—A Threat to Life." *Journal of the American Medical Association,* August 19, 1961.



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The Doctor's Library

Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

THE SEA WITHIN. The Story of Our Body Fluid. By William D. Snively, Jr., M.D., Lecturer in Pediatrics, University of Louisville School of Medicine; Attending Physician, Evansville Child Health Conferences; Medical Department, Mead Johnson & Company. Philadelphia and Montreal: J. B. Lippincott Company, 1960.

"The Sea Within" is a splendid, serious effort on the part of Dr. Snively to present the basic concepts of the constant metabolic activity within the human body and in particular to the vehicle for these reactions—the body fluid. This is written primarily as a popular presentation for the layman in the hope that it might broaden his horizon, particularly in respect to basic physiology. It would also serve as an instructive, painless primer to those students more seriously interested in the fluid and electrolyte problem. It is concise, easily read and certainly highly recommended for those interested in the miracle of human life.

J.G.G.

HANDBOOK OF SURGERY. Edited by John L. Wilson, M.D., Chief of Surgery, Veteran's Administration Hospital, San Francisco, California; Associate Clinical Professor of Surgery, University of California School of Medicine, San Francisco, California. Joseph L. McDonald, M.D., Dean of the Faculty of Medical Sciences, American University of Beirut, Beirut, Lebanon. Formerly Professor of Surgery, Columbia University, New York. Los Altos, California: Lange Medical Publications, 1960. Price, $4.00.

This is a fresh contribution to the handbook series by the Lange Medical Publications containing the essentials of basic diagnosis and non operative management of the common surgical diseases. The book is of pocket size, systematically presented and accompanied by multiple lucid illustrations. All subspecialties are represented including pediatric, plastic, gynecological, urologic and orthopedic sections. Useful dosage schedules of the common drugs are included.

This will undoubtedly serve as a readable, readily available source of information to house officers associated with the various surgical services as well as a ready office reference for general practitioners and surgeons alike.

J.G.G.

STROKE. A Study of Recovery. By Douglas Ritchie. Garden City, New York: Doubleday & Company, Inc., 1961. Price, $3.50.

This is an interesting account, written for popular consumption, by a British layman, who was the victim of a stroke at about fifty years of age. During his long convalescence, he kept a diary of the many trials and subjective responses to this long ordeal. It was this diary that served as the basis of his interesting and personal account. Especially interesting are his reactions to the various situations as they developed.

The book gives the professional reader an interesting insight into the patient's concept and reactions to such a long, chronic, debilitating illness, and the fight along the long road to recovery.

With this idea in mind, it is interesting, easy, reading in slightly under 200 pages.

An interesting final chapter, entitled "An Aphasic's Addenda" contains many practical suggestions for sufferers of stroke from the victim's point of view, which are not found anywhere else. The book would make interesting reading for any recuperating stroke victim.

R.W.B.

HOSPITALS, DOCTORS, AND DOLLARS. Reports and Opinions on Our Good Samaritans, Who Are Having Some Bad Times. By Robert M. Cunningham, Jr. Editor, The Modern Hospital. New York: F. W. Dodge Corporation, 1961. Price, $6.95.

This book is an interestingly written collection and assemblage of previously published articles and comments, and is timely. It is published by the editor of a modern hospital, who has a personal interest in hospitals. This gives all sides of the question of hospitals in America and England, the development of socialized medicine there, conditions of the hospitals and conditions of the doctors. Same comments here.

The author discusses from every angle the costs of hospital and medical care, showing the many instances where actually that cost appears great, it is not in actual values, any greater than it used to be. In money, yes, but in contributions and facilities and abilities, the costs haven't gone too far.

With conditions as they are prevailing now and the attempt to take over control or supervise control, we have been happy to study this book. We think our readers would enjoy it and, in reading it, would take comfort in their troubles and courage in their frustrations.

MANAGEMENT OF OBSTETRIC DIFFICULTIES. Revised by J. Robert Willson, M.D., M.S., Professor of Obstetrics and Gynecology, Temple University School of Medicine; Head of the Department of Obstetrics and Gynecology, Temple University Medical Center. 323 text illustrations; 1 color plate. Sixth edition. St. Louis: The C. V. Mosby Company, 1961. Price, $16.50.

This revised text includes the newer diagnostic procedures and treatments which can be used in the physician's office or hospital. As in previous editions of this book, its value is as a reference and not as a basic text. The book is divided into eight sections, namely—Infertility, Diagnosis of Pregnancy, Duration of Pregnancy, Complications of Labor, Obstetric Operations, Complications of the Puerperium, Special Therapy, and The Newborn Infant.

The chapter on chorio-epithelioma and chorio-carcinoma and hydatidiform mole are very inclusive, as is the chapter on obstetric analgesia and anesthesia.

Photographs and diagrams are especially well done and are self explanatory.



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The final chapter on the newborn infant was written by Dr. Victor C. Vaughn and Dr. Wm. E. Laupus. The treatment of respiratory disturbances is of special interest.

There are excellent references listed at the end of each chapter.

J.R.P.

ADRENERGIC MECHANISMS. Ciba Foundation Symposium Jointly with Committee for Symposia on Drug Action. Editor for the British Pharmacological Society—J. R. Vane, B.Sc., D.Phil. Editors for the Ciba Foundation—G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Maeve O'Connor, B.A. 163 illustrations. Boston: Little, Brown & Company, 1961. Price, $12.50.

This book is the report of a conference of research workers on the subject of the role of adrenergic mechanisms in the regulation of body function. As in previous Ciba Symposia, a series of papers is presented, following by a transcript of general discussion, in most instances. References are well documented. Illustrations are in black and white, and are quite adequate. The work is primarily of interest to those engaged in active research in the field.

R.W.B.

METABOLIC EFFECTS OF ADRENAL HORMONES. Ciba Foundation Study Group No. 6 in honor of Prof. G. W. Thorn. Editors for the Ciba Foundation—G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Maeve O'Connor, B.A. 16 illustrations. Boston: Little, Brown and Company, 1961.

This small booklet of slightly over 100 pages, contains the proceedings of a one-day conference on the Metabolic Effects of Adrenal Hormones, sponsored by the Ciba Foundation, convened in honor of George W. Thorn of Harvard University.

Each of the several papers is followed by a transcript of the general discussion, which is particularly interesting.

The papers are of interest primarily to those engaged in research and those interested primarily in the purely scientific aspects of the subject.

BOOKS RECEIVED

A SYNOPSIS OF CONTEMPORARY PSYCHIATRY. By George A. Ulett, B.A., M.S., Ph.D., M.D., Professor of Psychiatry, Department of Psychiatry and Neurology, Washington University School of Medicine, St. Louis, Mo.; Director of Psychiatric Services, Hospital Division, City of St. Louis, St. Louis, Mo.; Medical Director, Malcolm Bliss Mental Health Center, St. Louis, Mo., and D. Wells Goodrich, M.D., Chief, Biosocial Growth Center, National Institute of Mental Health, National Institutes of Health, United States Public Health Service, Department of Health, Education and Welfare, Bethesda, Md. Second edition. St. Louis: C. V. Mosby Company, 1960. Price, $6.50.

CARCINOGENESIS. Ciba Foundation Symposium. Mechanisms of Action. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch. and Maeve O'Connor, B.A. 48 illustrations. Boston: Little, Brown and Company, 1961. Price, $9.50.

REGULATION OF CELL METABOLISM. Ciba Foundation Symposium. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch. and Cecilia M. O'Connor, B.Sc. 109 illustrations. Boston: Little, Brown and Company, 1961. Price, $9.50.

MEANING AND METHODS OF DIAGNOSIS IN CLINICAL PSYCHIATRY. By Thomas A. Loftus, M.D., Associate Professor of Clinical Psychiatry, The Jefferson Medical College, Philadelphia, Pennsylvania. Philadelphia: Lea and Febiger, 1960. Price, $5.00.

W. B. Saunders Company features the following recent books in their full-page advertisement appearing elsewhere in this issue:

DRIPPS, ECKENHOFF AND VANDAM—INTRODUCTION TO ANESTHESIA. An ideal basic guide to the understanding and safe administration of anesthesia.

CORDAY AND IRVING—DISTURBANCES OF HEART RATE, RHYTHM AND CONDUCTION. Covers management of *all* the cardiac arrhythmias and conduction defects,

A TRAVELER'S GUIDE TO GOOD HEALTH. By Colter Rule, M.D. Dolphin Books. Garden City, New York: Doubleday & Company, Inc., 1961. Price, 95 cents.

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Rx for Medics

New York Journal American, June 27, 1961

"Cure thy profession, physician," is the socio-political remedy prescribed to the nation's doctors at the current meeting of the American Medical Association.

Diagnosis shows definite signs of excessive fees, unnecessary surgery, unethical conduct and professional incompetence.

Admittedly these symptoms have appeared among only a small fraction of the 250,000 licensed physicians in the United States; but any doctor worth his Rx pad knows that infection requires prompt, specific and sometimes drastic treatment to prevent its spread.

What one AMA committee called a "hear-no-evil, see-no-evil attitude of many doctors," who are reluctant to penalize colleagues, certainly is not the recommended treatment.

Self-discipline within the medical profession is the least painful and least embarrassing course physicians can take, or else the public—their patients—will demand strong doses of harsher purgatives. And no doctor will be able to argue that he hadn't been warned.

VD Increases in Michigan

Michigan experienced an alarming 221 per cent increase in infectious syphilis during the first quarter of this year over the same period of 1960, a peak year. Of greatest concern to state health authorities is the increase among teenagers. Fourteen of them contracted syphilis in the first three months of this year compared with only four at that time a year ago. A 13 per cent increase in gonorrhea was recorded among teenagers also.

First quarter figures, which are provisional and accordingly subject to some increase as delayed reports are received, showed 77 cases of primary and secondary (early, infectious) syphilis. This was 53 more than during the first quarter of 1960. Gonorrhea showed a 8.6 per cent increase with 2,309 cases reported, 183 more than last year. There were 41 more cases among teenagers than there were a year ago at this time.

KELLOGG HELPS—A grant of $1,073,200 by the W. K. Kellogg Foundation will aid Rutgers University of New Brunswick, New Jersey, to establish a School of the Basic Medical Sciences. Since early 1960, the Foundation has aided the establishment or expansion of schools also at the Universities of Connecticut and New Mexico and at Dartmouth College in New Hampshire.

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COMMUNICATIONS

Mr. Hugh W. Brenneman
Public Relations Counsel
Michigan State Medical Society

Dear Mr. Brenneman:

Thank you very much for the political action material that you sent us for our display at the AMA Public Relations Institute. We used it on the exhibit labeled *"Grass Roots"—Legislative Action Materials.* The extra copies were put on a table for a materials exchange.

Your small pamphlets were very well done and we wish we had had more for administrators of other states to pick up at our materials exchange table.

Thanks again.

Sincerely yours,
JACK E. RYON
Division of Field Service
American Medical Association

Chicago, Illinois
September 1, 1961

•

Wilfrid Haughey, M.D.
Editor, The Journal MSMS

Dear Doctor Haughey:

I would like to congratulate you and your Editorial Board on the editorial titled "Running Scared" which appeared in THE JOURNAL of the Michigan State Medical Society for September of 1961.

It doesn't really seem necessary that the medical profession, with so many individual successes in the way of cures of the vast percentage of one's patients, should ever have to be on the defensive in presenting our case to the public. However, the national trend towards security and apathy, as far as public events are concerned, seems occasionally even to infect our fellow physicians.

I would feel that this article should repeatedly be emphasized to all our councilors and spokesmen for any segment of the medical profession, no matter how small.

Again, congratulations on the presentation of a positive rather than a negative philosophy.

Very sincerely yours,
WILLIAM T. DAVISON, M.D.

Port Huron, Michigan
October 11, 1961

•

Dr. Otto K. Engelke,
President,
Michigan State Medical Society

Dear Doctor Engelke:

I would like to express my deep appreciation for your kind invitation to attend the Session of the Michigan State Medical Society, recently held in Grand Rapids.

While I was able to attend only the business meetings of the first two days, I was impressed by the conduct of your House of Delegates, and I might say that I have never seen a better informed House as a whole, concerning the problems that face organized medicine. You are to be warmly congratulated on the way in which you disseminate information. If every state would follow your example, I think we could reduce our problems to a minimum.

Sincerely yours,
G. A. OWSLEY, M.D., President
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During the year 1960 approximately $100,000,000 were expended on research for heart diseases. In the field of mental health, the research expenditures were about $105,000,000, of which the largest share, $100,000,000, came from the Federal Government.

* * *

Unemployment compensation—jobless pay—in this country is higher than the average hourly wages for employed factory workers in most of Europe.

the Journal MICHIGAN
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Volume 60 Number 11
November, 1961

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THE COVER

The illustration shows a band composed of the elements which are responsible for the contraction of the heart (actomyosin). This band was prepared from human hearts obtained from autopsy. The contraction of this small band has been used to investigate the mechanisms of heart failure in man. Photograph furnished by Richard J. Bing, M.D., Chairman, Department of Medicine, Wayne State University.

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Wm. Arendshorst, M.D. — Holland
Co-Chairman (Ophth.)

Pediatrics

Scott T. Harris, M.D. — Ypsilanti
Chairman
Bernard H. Siebers, M.D. — Grand Rapids
Secretary

Public Health and Preventive Medicine

C. E. Reddick, M.D. — Bay City
Chairman
G. Frederick Moench, M.C. — Midland
Secretary

Radiology, Pathology, Anesthesiology

John W. Ditzler, M.D. — Detroit
Vice Chairman (Anesthesiology)
C. Allen Payne, M.D. — Grand Rapids
Secretary (Pathology)

Surgery

Philip J. Huber, M.D. — Detroit
Chairman
Alexander W. Blain III, M.D. — Detroit
Secretary

Urology

Jack Lapides, M.D. — Ann Arbor
Chairman
Murray S. Mahlin, M.D. — Detroit
Secretary

DELEGATES TO A. M. A.

Delegates

	Term Expires
J. S. DeTar, M.D., Milan	1961
W. A. Hyland, M.D., Grand Rapids, *Chairman*	1961
O. J. Johnson, M.D., Bay City	1961
C. I. Owen, M.D., Detroit	1961
Wm. Bromme, M.D., Detroit	1962
R. L. Novy, M.D., Detroit	1962
G. W. Slagle, M.D., Battle Creek	1962

Alternates

	Expires
W. W. Babcock, M.D., Detroit	1961
G. B. Saltonstall, M.D., Charlevoix	1961
J. M. Wellman, M.D., Lansing	1961
B. M. Harris, M.D., Ypsilanti	1961
L. R. Leader, M.D., Detroit	1962
J. R. Heidenreich, M.D., Daggett	1962
D. N. Sweeny, Jr., M.D., Detroit	1962

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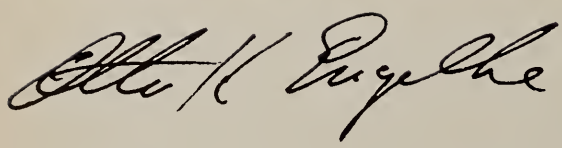
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President's Page

CON-CON DELEGATES—AND YOU





President
Michigan State Medical Society

President's Pages are written quite a few weeks in advance of the time they are read. Consequently, on such a topical subject as the Constitutional Convention, it is difficult to project comment which will subsequently jibe with developments.

However, certain factors relating to Con-Con are fundamental and important. I invite your attention to them because your actions and mine can affect both medical practice and our everyday living patterns.

Most important is that we keep up-to-date on Con-Con issues; that we know the facts regarding these issues. And then, applying good judgment, we should express our opinions. Generally, we are in a better position to accomplish this than the great majority of Michigan citizenry.

Everyone accepts such advice and comment if it comes from someone they know and trust—and the Con-Con delegate is no exception. These delegates are performing a valuable service as they study the great issues of government whether their work is finally approved or not. Many of them are doing this work at a financial loss and with a significant sacrifice of time. By and large, they are dedicated people. We can do no less than recognize these facts. And having recognized them, our approach to the delegate offering our information and service cannot help but be properly given and well received.

County Medical Societies which take steps to invite Con-Con representatives to meet with them—just as they host state and national legislative representatives—to explore subject areas of general concern to citizens as well as those of particular interest to medicine, will be rendering a fine service to both their profession and their state.

Doctor Engelke Installed; Doctor Owen Elected



Otto K. Engelke, M.D., Ann Arbor, was installed at the 1961 Annual Session at Grand Rapids as President for the Michigan State Medical Society for 1961-1962. He was installed by Kenneth H. Johnson, M.D., Lansing, who was lauded for his outstanding service as President, Speaker of the House and Vice-Speaker.

Clarence I. Owen, M.D., Detroit, was the unanimous choice as President-Elect. An interesting sidelight will develop next year when Doctor Owen is installed as president for 1962-1963—he will be President for two days while his wife is completing her current year as President of the Woman's Auxiliary. This will be the first time in MSMS history that the top offices in the two organizations have been held by husband and wife.

* * *

IN THE HOUSE of Delegates election, James J. Lightbody, M.D., Detroit, and Harold F. Falls, M.D., Ann Arbor, were re-elected as Speaker and Vice-Speaker, respectively.

The House elected the following Councilors—William S. Carpenter, M.D., and Edgar E. Martmer, M.D., both of Detroit; Harvey C. Hansen, M.D., Battle Creek; William A. Scott, M.D., Kalamazoo, re-elected; C. Allen Payne, M.D., Grand Rapids, re-elected; H. H. Hiscock, M.D., Flint, re-elected; D. Roemer Smith, M.D., Iron Mountain; and Bradley M. Harris, M.D., Ypsilanti, re-elected. Dr. Carpenter fills the Councilor post formerly held by Arthur E. Schiller, M.D., Detroit; Dr. Hansen succeeds H. J. Meier, M.D., Coldwater; and Dr. Smith succeeds T. P. Wickliffe. M.D., Calumet—all three men resigning their positions.

* * *

IN THE REORGANIZATION of The Council, O. B. McGillicuddy, M.D., Lansing, was chosen as the new Chairman to succeed Dr. Meier. O. J. Johnson, M.D., Bay City, was selected Vice-Chairman, to succeed Dr. Wickliffe.

Three new chairmen of Council standing committees were selected —Dr. Mason, County Societies Committee; Dr. Scott, Publications Committee, and Warren W. Babcock, M.D., Detroit, Finance Committee.

The following were elected AMA Delegates—W. A. Hyland, M.D., Grand Rapids; O. J. Johnson, M.D., Bay City; Luther R. Leader, M.D., Detroit; J. R. Heidenreich, M.D., Daggett.

The following were elected AMA Alternate Delegates—G. B. Saltonstall, M.D., Charlevoix; J. M. Wellman, M.D., Lansing; Sidney Adler, M.D., Detroit; B. M. Harris, M.D., Ypsilanti.

The following were elected to fill unexpired terms of Alternate Delegates: C. I. Owen, M.D., Detroit; R. E. Rice, M.D., Greenville.



Visiting with the guard in front of the bungalow-entrance to the exhibits are Albert E. Heustis, M.D., Lansing, state health commissioner, and Louis Bailey, M.D., Detroit, assistant-editor of the JOURNAL.

1961 Annual Session Offers Colorful Events





Mrs. Clarence I. Owen, left, Detroit, was installed as the new president of the Woman's Auxiliary. Left to right with Mrs. Owen are Mrs. J. Earl McIntyre, Lansing, installing officer; Mrs. Paul Ivkovich, Reed City, outgoing president, and Mrs. Ross V. Taylor, Jackson, president-elect.

One of the entries in the Auxiliary-sponsored Art Exhibit is admired by C. Allen Payne, M.D., right, Grand Rapids, counselor; Mrs. Robert Emerick, Fremont, exhibit chairman, and Mr. Robert Yonkers, Director of Hackley Art Gallery, Muskegon.



A certificate of appreciation is given to Kenneth H. Johnson, M.D., right, outgoing MSMS president, by Otto K. Engelke, M.D., new president, before the House of Delegates.



George P. Raynale, M.D., is mighty proud of the citation as "Michigan's Foremost Family Physician" following his election by the House. James J. Lightbody, M.D., right, speaker of the House, made the presentation.



The coveted Michigan State Medical Society 50-Year Award was given at the 1961 Annual Session at Grand Rapids to the following men: Seated *(left to right)* Raymond S. Goux, M.D., Detroit; Howard H. Cummings, M.D., Ann Arbor; Robert D. Scott, M.D., Flint; Henry J. Vandenberg, M.D., Grand Rapids; Henry R. Carstens, M.D., Birmingham. Standing *(left to right)* George R. Goering, M.D., Flint; Joseph A. Bakst, M.D., Detroit; Elisha S. Sevensma, M.D., Grand Rapids; Ernest W. Dales, M.D., Grand Rapids; G. Howard Southwick, M.D., Grand Rapids; LeRoy W. Hull, M.D., Detroit, and Charles J. Jentzen, M.D., Detroit. Also receiving the award were: Wyman D. Barrett, M.D., Glen B. Carpenter, M.D., Harry F. Dibble, M.D., R. R. Goldstone, M.D., and H. Walter Reed, M.D., all of Detroit, and Buenaventura Jimenez, M.D., Ann Arbor.

Honor 20 Members For 50 Years of Service

One thousand years of medical service to the people of Michigan were recognized at the annual meeting of the Michigan State Medical Society.

Twenty doctors were honored by the MSMS House of Delegates for having completed 50 years of service each. Thirteen men were present to receive their 50-year pins; the others will receive theirs by mail.

The doctors who were honored were:

Ann Arbor—Howard H. Cummings, Buenaventura Jimenez.

Bellevue—Fred L. Arner.

Birmingham—Henry R. Carstens.

Detroit—Joseph A. Bakset, Wyman D. Barrett, Glenn B. Carpenter, Harry F. Dibble, R. R. Goldstone, Raymond R. Goux, LeRoy W. Hull, Charles J. Jentgen, H. Walter Reed.

Flint—George R. Goering, Robert D. Scott.

Grand Rapids—Ernest W. Dales, Elisha S. Sevensma, Ansel B. Smith, G. Howard Southwick, Henry J. VandenBerg.

Woman's Auxiliary Elects Officers

The Woman's Auxiliary to the Michigan State Medical Society elected officers as one of the highlights at the annual meeting at Grand Rapids.

Mrs. Ross V. Taylor, of Jackson, was elected President-Elect.

The ceremonies featured the installation of Mrs. Clarence I. Owen, Detroit, as president for 1961-62. She succeeds Mrs. Paul Ivkovich, Reed City.

Selected with Mrs. Taylor at the annual election were: Mrs. H. J. Himmelberger, Lansing, First Vice President; Mrs. Milton R. Weed, Detroit, Second Vice President; Mrs. Ernest Griffin, Flint, Recording Secretary; Mrs. F. P. Rhoades, Detroit, Financial Secretary, and Mrs. Robert Clarke, Grosse Pointe, Treasurer.

Elected as District Directors were: Mrs. Earl Weston, Birmingham; Mrs. Grover Fattic, Niles; Mrs. Charles Schoff, Midland; Mrs. John Heidenreich, Daggett; Mrs. Jerald Drake, Petoskey.

In addition to an excellent program and active business meeting, the Auxiliary received many compliments for the Art Exhibit which it inaugurated this year. Doctors and their wives were invited to exhibit, and the display showed many fine works at the Pantlind Hotel lobby balcony.

What They Said About the Annual Session

On behalf of the senior representatives to the House of Delegates meeting from Wayne State University, I should like to express our deepest thanks to you and the Society for granting us the privilege to be in attendance. We found the meetings interesting as well as very informative. I have personally expressed my feelings to the officers of our Junior and Sophomore classes and I can assure you that the full complement of six representatives from Wayne State will be present next year should the invitation be again extended.

Drake Duane, *President*
Wayne State University
Chapter of Student
American Medical Association

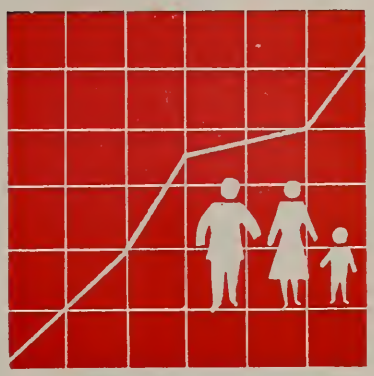
I would like to express my deep appreciation for your kind invitation to attend the Session of the Michigan State Medical Society, recently held in Grand Rapids. While I was only able to attend the Business Meetings of the first two days, I was impressed by the conduct of your House of Delegates, and I might say that I have never seen a better informed House as a whole, concerning the problems that face organized medicine. You are to be warmly congratulated on the way in which you disseminate information. If every state would follow your example I think we could reduce our problems to a minimum.

G. A. Owsley, M.D., *President*
Indiana State Medical Association

MICHIGAN MEDICAL MEETINGS AND CLINIC DAYS

December 6	Annual Symposium on Trauma	Detroit
January 25-26	Symposium on Blood	Michigan State University, East Lansing
February 3	County Secretaries-Public Relations Seminar	Wayne County Medical Society, Detroit
February 3	Michigan Society of Gerontology	Muskegon—Occidental Hotel
February 10	Michigan Heart Day	Statler Hotel, Detroit
February 9-10	Congress of the Professions	Kellogg Center, East Lansing
Feb. 28, March 1-2	Michigan Clinical Institute	Detroit

Numerous Changes Found In Michigan Population



Michigan has undergone many population changes since 1950—changes in number, distribution and composition, according to J. F. Thaden, Michigan State University population expert.

His recent study shows the following facts: Its numerical increase of 1.4 million is the largest in history. Its natural increase (1,917,903 births less 628,707 deaths) was supplemented by net in-migration of 162,232 persons. Michigan was one of 23 of the 50 states that, on balance, had a greater in-migration than out-migration.

The urban population of Michigan increased from 70.7 per cent of the total in 1950 to 73.4 per cent in 1960. Twenty-three counties have more urban than rural people as the terms are defined by the Census Bureau.

The percentage of population in the Michigan Standard Metropolitan Statistical Area's increased from 66.3 per cent in 1950 to 73.1 per cent in 1960. The proportion of the population who will be living in urban and urban fringe areas will certainly continue to increase during the 1960's.

* * *

THE BABY BOOM OF the postwar years has increased the number of young folks. Since 1950 persons under 20 years increased by nearly a million, or 45 per cent. There are now 1,989,576 of school age, 5 to 17, or more than half as many again as the 1,297,715 in 1950.

The population in the intermediate age group 20 to 64 increased from 3,734,492 to 4,029,086, only 7.9 per cent.

Increasing longevity has boosted the number of persons 65 years and over from 461,650 to 638,184, an increase of 44 per cent in a single decade.

"The relatively rapid increase of children and teen-agers, and people of retirement age, has increased the burden on persons of working age. A decade ago 100 persons in the economically independent age group had only 71 dependents to support besides themselves. Now they have 94 dependents to provide for," Dr. Thaden declared.

Manpower gained less than womanpower in Michigan from 1950 to 1960. Manpower (number of men 20-64 years) increased 10.4 per cent.

* * *

MICHIGAN, FOR THE FIRST time in history, now has a larger female than male population. The ratio of 101.7 men per 100 women in 1950 changed to 98.5 men per 100 women by 1960.

The nonwhite population of Michigan continues to increase more rapidly than the white, a trend that began about 1920. It is a national trend that was accentuated as a result of reduced immigration. Since 1920, the decennial increase of the white population

of this state averaged 19 per cent; the nonwhite 90 per cent. Between 1950 and 1960 the white population increased 19.7 per cent, and the nonwhite 62.4 per cent.

Negroes in Northern states are usually concentrated in cities and within certain areas of cities. However, Michigan has Negro settlements in 23 entirely rural counties. Wayne, the most urban county, ranks second highest in proportion of Negroes—one in five. Detroit has nearly half a million Negroes (482,223) who constitute 28.9 per cent of its total population.

* * *

DR. THADEN OBSERVES: "The population of Michigan is dynamic, ever changing. Rapidly changing distribution and composition of population frequently create serious problems for those concerned with the welfare of youth and of the aged, and of the breadwinners supporting their dependents. There is a need for social institutions—the schools, churches, welfare agencies, public utilities, municipalities, and governmental bodies—to keep abreast of changing demographic trends and be ready to make adjustments."

Federal Bureau Reports Drop in Prescription Prices

Prescription prices, says the Bureau of Labor Statistics of the U.S. Department of Labor, are moving down. In a report published in May, 1961, the Bureau showed that prices for prescriptions were continuing their downward trend which began last June.

The Consumer Price Index of the Bureau of Labor Statistics shows that from 1949 through 1959 drug prices have risen about half as much as total medical care costs and slightly less than the cost of living as a whole.

What is the price of the average prescription? A survey published in the April 3, 1961, issue of *American Druggist* showed that in 1960 the price most frequently charged for prescriptions was $1.25, $1.50 and $2.00. The Average prescription price was $3.25.

Confusion about drug prices sometimes results from failure to distinguish between prescription prices and prescription expenditures. The average American in 1959 spent nearly three times as much for prescriptions as he did in 1949. But this does not mean prescription prices were three times as high in 1959 as they were a decade earlier. Statistics published by *American Druggist* explain this: Americans simply were buying more drugs in 1959. Since 1949 the average number of prescriptions filled per person rose from about 2 to more than 3.5.

One reason people are buying more prescription drugs is that today many potent new drugs are available to treat illnesses that ten years ago could not be treated at all.

Today's potent new medicines often lower the cost of being ill. In the past, people who contracted pneumonia had to spend several weeks in the hospital, plus weeks of convalescence, at a cost of at least $300 to $400. Today, pneumonia can often be cured at home in a short time with less than $20 worth of antibiotics.

"Member Council" Started By Blues at Saginaw

The second of a planned statewide network of grassroots Blue Cross-Blue Shield "Member Councils" has been formed in Saginaw. The pioneer Member Council in Lansing held its fifth meeting in September.

The "Member Councils" are aimed at developing forceful and independent community-level forums to establish closer contact between Blue Cross-Blue Shield and the doctors and the hospitals on the one hand and Blue Cross-Blue Shield members on the other.

Drug Counterfeiting

The counterfeiting of drugs poses a threat to the ethical manufacturers, their retail outlets, the prescribing physician, and the consumer.

The Food and Drug Administration in a recent investigation examined 2,700 samples from 900 drug stores selected at random between January 24, 1961, and March 30, 1961. It found nine samples from nine stores to be counterfeit—a small number to be sure, but when projected across the total number of products and drug stores . . . a finding of some magnitude.

The drugs most commonly counterfeited are those with a high volume of sale—tranquilizers and oral diuretics. They are made in precise simulation of well-known trademarked products even to the reproduction of monograms. They are invariably substandard, not being subject to the rigid quality control of the original manufacturer. They can be detected only by microscopic and chemical examination. Their distribution is always surreptitious, and this puts a great responsibility on the retail pharmacist. All retailers should insist on accepting drugs only in original sealed manufacturer's packaging.

The Pharmaceutical Society of the State of New York, aware of this, is conducting a campaign among its members and through advertising in the public press to stamp out illegal trade of this nature.

Direct police action has been taken by the Food and Drug Administration and by those states that have laws governing drug counterfeiting. Government action, plus the vigilance of each ethical pharmacist acting individually and through his pharmaceutical association, can solve this problem and assure the patient that he will obtain not a substandard product but what his physician prescribes.—*New York State Journal of Medicine*, August 15, 1961.

Genesee Doctors Aid Flint Development

Doctors of medicine in Genesee County have been in the spotlight this fall.

And the recognition was merited!

More than 100 Genesee doctors contributed $1,000 each to provide a $107,000 sponsorship to Flint's College and Cultural Development.

In announcing the contribution, the M.D. Committee said "the doctors looked upon the opportunity to assist the Development as another way the medical profession can continue to work for the betterment of the community."

* * *

CARL W. BONBRIGHT, president of the Development's Committee of Sponsors, in accepting the fund commented: "Members of the Genesee County Medical Society long have been identified with a host of good works through their beneficences and volunteer services." He added that "We feel the joint gift of the medical doctors will encourage other organized groups to make similar efforts. Flint and Genesee County citizens can thus doubly benefit from this support."

It was pointed out too by the Development Committee that doctors have supported the College and Cultural Development since its beginning, and that a number of them have already provided gifts of $25,000 or more.

* * *

IN MAKING the donation, the M.D. committee explained that "The many and varied facilities of the College and Cultural Development and the others planned for the future fall right in line with our thinking about what Flint needs and what the world needs."

Movie About Pathologists

"The Young Doctors," which was shown exclusively to physicians at AMA's Annual Meeting in New York, has been released to theaters through the nation.

The film, starring Fredric March, Ben Gazzara and Ina Balin, was made with the cooperation of AMA Physicians Advisory Committee on Television, Radio and Motion Pictures.

Charles F. Begg, M.D., chief pathologist of St. Luke's Hospital, New York, served as technical advisor during the filming. The motion picture portrays the work of pathologists in the metropolitan hospital. Much of the movie was made inside New York hospitals.



Milton Darling, M.D., Detroit, accepts the trophy awarded to MSMS, "the best large exhibit at the 1961 State Fair." Presenting the award on behalf of the State Fair Commission is Newscaster John Cameron Swayze.

MSMS Exhibit Judged "Best" at Michigan State Fair

Michigan State Medical Society was accorded first place honors for the best large exhibit at the 112th Annual Michigan State Fair. The trophy was presented by Newscaster John Cameron Swayze on behalf of the State Fair Commission and accepted by Milton Darling, M.D., Detroit, immediate past president of the Michigan State Medical Society.

Striking in its simplicity, the Medical Society's educational display featuring "Careers in Medicine," pointed out through signs and pamphlets that "more physicians, nurses, medical technologists and medical assistants are needed to advance the world's best medical care."

Attendants at the booth dispensed literature concerning the spectrum of medical careers as well as folders warning against medical quackery, treatment of diabetes, cancer, heart disease, and other ailments.

During the course of the 10-day fair, more than 120 volunteers dispensed a total of 8,640 polio inoculations, 3,230 blood pressure readings, and 2,710 diabetes detection kits. All of these services were made available to patrons of the State Fair without charge. Volunteers were recruited from amongst physicians, registered nurses, licensed practical nurses, medical assistants, medical technologists and medical students, in Macomb, Oakland, Washtenaw and Wayne Counties.

Also featured at the exhibit were stereophonic broadcasts through the courtesy of WDTM-FM, which also sponsors the Medical Radio News Program.

One of the highlights of the week at the exhibit was a visit by 12 Congolese Medical Students representing the first

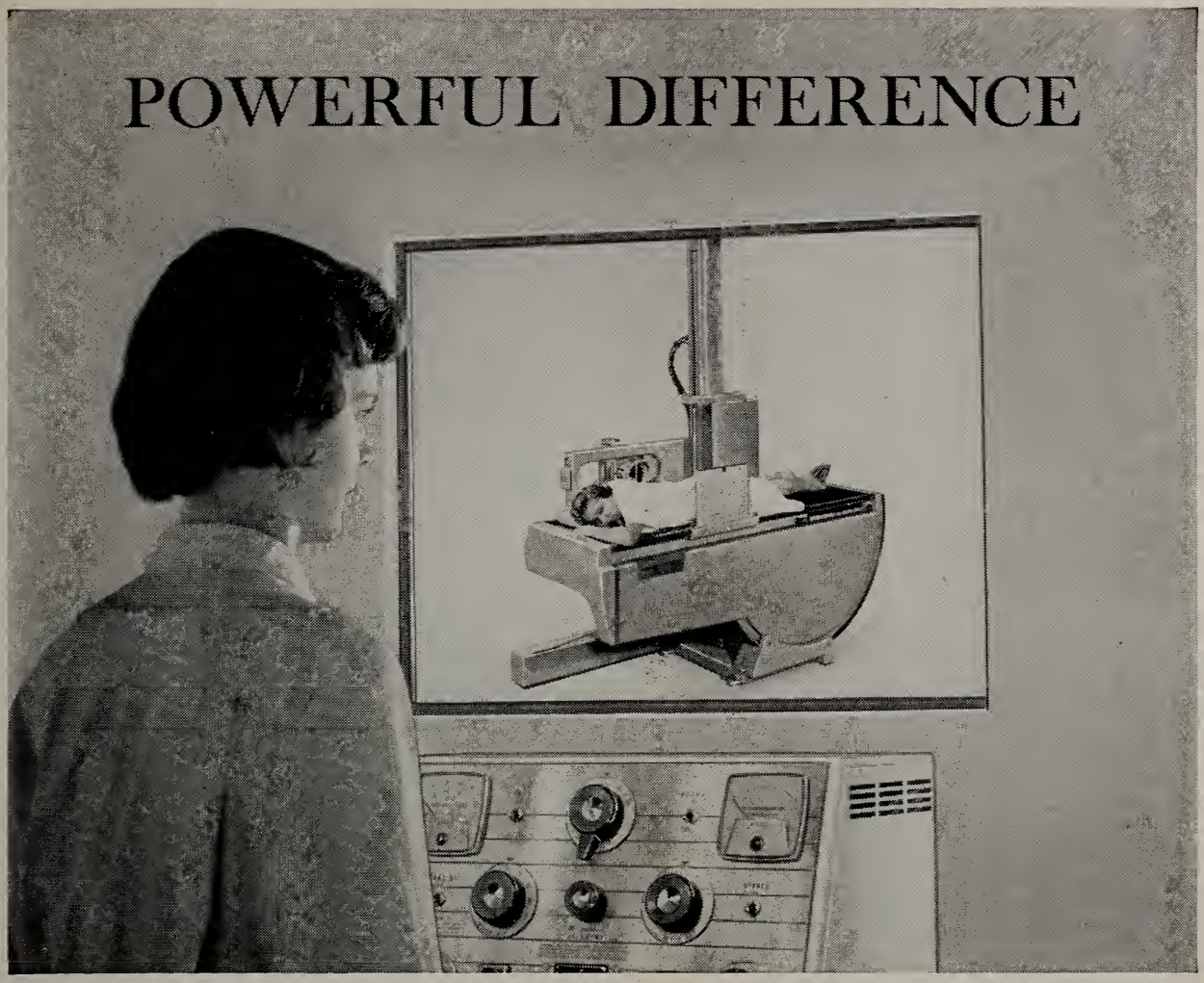
(Turn to Page 1394)



Francis S. Gerbasi, Macomb County physician, administers polio inoculation to one of the 8,640 state fair patrons who visited the MSMS Exhibit.



George Clifford, M.D., Detroit, explains the function of the hypo-spray "gun" to a group of Congolese medical students who visited the MSMS "Careers in Medicine" exhibit. Interested observer looking over Dr. Clifford's shoulder is Michigan's Governor John B. Swainson.



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generation of modern physicians in that new country. The group spent ten days at state and county health departments and at the University of Michigan.

The exhibit space was divided into three areas, each of which stressed the need for recruits in one of the fields of medicine. One section emphasized opportunities in nursing (practical and registered), one emphasized Medical Technologists and Medical Assistants and the third, called attention to the need for additional physicians.

WKAR-FM Serves Doctors

Radio Station, WKAR-FM, East Lansing, carries a new medical news service expressly for physicians in the Lansing area, produced in cooperation with the Michigan State Medical Society. This program is presented each Thursday evening immediately preceding WKAR's regular one-half hour program devoted to medical research.

The weekly "package," prepared by the MSMS staff, includes announcements of forthcoming medical meetings and events, up-to-the-minute news items covering all phases of the medical field, and an abstract of a recent study, lecture, or article of current interest to physicians.

Doctor Is Hero To College Youths

The college student's current hero is the doctor, because "he possesses high intelligence but maintains a close touch with concrete reality."

And close behind are the lawyer and the college professor—if he made a bit more money—according to a five-year study being done for the U. S. Office of Education by Dr. Donald D. O'Dowd and Dr. David C. Beardslee, psychology professors at Michigan State University-Oakland.

In a survey of 1,200 students at several different colleges—both public and private—the business executive and scientist ran behind.

Professor O'Dowd and Beardslee said the students questioned had little working knowledge of most of the 15 occupations rated. But the students agreed closely on a distinct image of the type of person in each job, of his social life and of the people he associates with.

Students say the doctor "not only is richly rewarded by high social status, wealth and success for extremely valuable and unselfish service to others, but he also can count on having an unusually pretty wife. He it at once masterful and gentle. He has no bad traits."

The doctor rated high in the traits students considered most important—cultured intellect, material and social success, sociability and personal and political responsibility.

One part of the survey asked students to list their occupational preferences, assuming they had all the necessary abilities and conditions that were ideal. The college professor took first by a neck, with the lawyer, doctor, business executive and scientist following in that order.

Professor O'Dowd and Beardslee concluded that college students "are far more interested in the personal relations, the personality traits and the style of life associated with an occupation than they are in the traditional goals of work and production."

1,000 Persons Help Set Association's Policy

The American Medical Association's broad activities for helping to improve the nation's well-being "sprout from a tree measuring a figurative 1,100 people high," according to the association's *Journal* (Oct. 10).

These persons, many of whom serve in weekend and late night sessions, donate as many as 100 hours yearly to the association. None is on the AMA payroll.

"The volunteering M.D.'s (and Ph.D.'s and LL.D.'s and B.A.'s too) range in name from A to Z and come from all 50 states," the *Journal* article said. "Their talents enrich 13 AMA councils, more than 100 committees, 20 sections of the Scientific Assembly, 10 specialty journals, and approximately a dozen liaison groups with other organizations."

In addition, there are members of the Board of Trustees and the House of Delegates, the group who makes the final policy decisions for the AMA.

Testimonial!

Nobody several years ago survived the series of illnesses that I have had. If someone tells me that the medicines I carry are expensive, I must laugh, particularly when I read circulars advertising graves. I would rather pay for a medicine than a gravedigger any day.

—George E. Sokolsky, columnist, King Features Syndicate.

Sudden Peripheral Arterial Occlusion And Its Many Causes

Herbert J. Robb, M.D.
Detroit, Michigan

SUDDEN arterial occlusion creates an immediate emergency. Early recognition and treatment are extremely important to the ultimate result. The purpose of this article is to emphasize the fact that at least one-third of the cases of acute arterial occlusion are not due to emboli. There are as many as six different causes for sudden arterial occlusion, and it is important to try to determine which of these factors are active in the individual case. Prognosis and treatment will vary greatly, depending on the differential causes.

The etiologic diagnosis is not always simple. It can be accounted for, however, by one of the following six processes in order of decreasing occurrence:

1. The arterial embolus
2. Sudden thrombosis beyond a chronic arterial block
3. The dissecting aneurysm
4. Agonal terminal hypotensive thrombosis
5. Thrombosis and embolism from an aneurysm
6. Massive venoarterial occlusion or phlegmasia cerulea dolens



The diagnosis of sudden arterial occlusion is made by recognition of the rapid development of symptoms characteristic of tissue ischemia. Any artery may be involved, and symptoms are peculiar to the part. In the extremities, the following symptoms develop in sequence: weakness, tingling, pain, numbness, collapse, and paralysis. Coldness, blanching, cyanosis, and mottling may soon be observed. There is a loss of pulse proximal to the level of symptoms. If circulation is sufficiently blocked, distal thrombosis ensues with a progression to an irreversible state of rigor mortis. A careful history and examination will usually indicate the probable cause for ischemia.

Arterial embolism[1,2] occurs with the dislodgment of a clot or fragment of tissue from the inside of the heart. Characteristically, these people have a history of rheumatic or arteriosclerotic heart disease. Commonly, these people have mitral vulvular disease, auricular fibrillation, or ventricular infarction with the development of a mural thrombus. On occasion we have observed the embolization of a calcified aortic valve leaflet. In about 50 per cent of the cases, however, the cause for embolism is not clear. In such instances, the

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patient may be young, the electrocardiogram normal, and the heart size normal. After a careful examination, we have discovered intracardiac tumors, patent septal defects, and have considered emboli from the pulmonary veins. Following hypotensive episodes requiring vasopressor drugs, patients develop soft intracardiac thrombi which embolize.

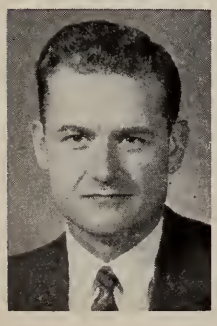
In the extremities, blockage will be sudden with no history of claudication. This is important to separate from the second group of patients having sudden arterial occlusion. An embolus will lodge at a bifurcation usually. The sites most common, in order of sequence, are the common femoral aortic, iliac, popliteal and axillary arteries. The site can be accurately predicted by locating the most distal pulses. Treatment is surgical. It is best to give 50 mgm of heparin intravenously as soon as the diagnosis is made, to prevent progression of the clot and cessation of flow in the capillaries. This also provides a loosening effect on the distal tail thrombus and makes its extraction much easier. It is important to "put the patient on ice," so to speak, until surgery can be done. Heparin can help prevent irreversible thrombosis of the capillaries which would mean failure to any operative procedure. Even though a pulse is present in the ankle on completion of a thrombectomy, it is futile if the capillary bed is thrombosed. Heparin does not contraindicate a spinal anesthetic or immediate surgery. Improvement by use of heparin or the use of spinal block is false and should not delay surgery. Emboli in the axillary, anticubital, and popliteal areas should be removed as well as those in larger vessels even though in the past there has been a tendency to consider these nonoperable areas. There is no period past which surgery is contraindicated, providing one still has an apparently viable extremity.

Surgery must be done immediately following recognition of the state and is directed at removal of the embolus which is located at the distal point of pulsation. There is usually a hard, organized embolic thrombus which can be palpated with the finger. Distal to this is a fresh red, soft tail clot, which does not always come out intact. In 50 per cent of embolectomies, it is necessary to make a distal common femoral, popliteal or posterior tibial artery incision and in a retrograde fashion wash out the distal clot. Frequently, a clot must be forced out of the posterior tibial artery through a distal incision, using a number 8 French ureteral catheter. Figure 1 is a diagram of an aortic embolus and two iliac artery tail clots. The aortotomy for the removal of the embolus is indicated. The iliac tail clots must be flushed out with saline, using the common femoral artery to insert a catheter, or by means of retrograde injection of saline through an 18-gauge needle inserted through the arterial wall. The operative results will be excellent, providing the embolus and tail clot are adequately removed, and providing capillary thrombosis has not occurred, adequate distal back flow of blood will indicate capillary patency. Preoperative stiffness of the joints or rigor mortis, on the contrary, will assure a very poor result. If back flow is not present, even though a postoperative pulse is existent in the post-tibial artery, one can predict subsequent rethrombosis. Padding a foot, or resting it on a pillow, and early use are important to prevent heel ulcer formation.

Immediate postoperative heparinization is synonymous with a hematoma and cannot be used safely. On the other hand, a recurrent embolus is very common when postoperative anticoagulants are not used. Within one week, it is common for these patients to reembolize, often to the same extremity. If we start anticoagulants in about two days, the tendency to reembolize is reduced. First, 50 mgm of heparin is given intravenously at night, then gradually the patient is completely anticoagulated. Three to four weeks of anticoagulant therapy seems sufficient to reduce the tendency to reembolize.

When emboli are recurrent, one must consider the possible sources. They most always originate in the heart, and open heart surgery may make it possible to remove the cause for recurrence. This is preferred to the former closed technique for removal of the left auricular appendage. Intracardiac tumors and septal defects may exist and can be overlooked or poorly handled by the closed method.

Thrombosis beyond a chronic block is the second most common cause for sudden peripheral arterial occlusion. It is often mistaken as an embolus, as it occurs suddenly in the vessels distal to a chronic segmental arterial block. Symptoms of ischemia may be just as severe as with an embolus. The presence of such a thrombus can be identified by the prior history of claudication. If the patient gives a history of tiredness or weakness in calf (or calf and thigh) after walk-



The Author

HERBERT J. ROBB, M.D.

ing, which is relieved by rest, a previous segmental arterial block must be anticipated. The pulse may well have been absent prior to the acute symptoms. This determination, of course, is important, for the operative procedure is considerably different than that anticipated with an embolectomy. A fresh thrombus has formed in the distal circulatory system where the blood pressure has been low and the flow slow. The thrombus must be removed from the distal segment and one must be prepared to insert an arterial graft from a point above into this area. The only hope for preservation of the extremity lies in utilization of this procedure, otherwise the artery will rethrombose. A high pressure of blood in the artery can keep it open and flowing. The success will not equal that with the usual patient selected for arterial grafting. Likewise, it does not approximate the usual success associated with the removal of an embolus.

Occlusion by a dissecting aneurysm is the third cause for sudden occlusion of an aortic branch vessel. This is not always possible to recognize prior to surgery intended for embolectomy. Characteristic tearing pain in the chest and back is not always present. We have seen the inominate artery, superior mesenteric, inferior mesenteric and common iliac arteries involved. Operative visualization of the abdominal aorta will not always immediately lead to the diagnosis, for the aorta is often of normal size and pulsation. Dilatation and the double aorta come later in the case where spontaneous reentry has occurred. The recognition, if not previously suspected, comes when one makes an incision over the occluded artery and discovers a clot which, when removed, does not present a true smooth white intima. A deeper incision will disclose the true inner arterial lumen. A reentry procedure, either in the abdominal or thoracic aorta, is the procedure of choice with tacking down of intima distal to the point of reentry.

Agonal premortem arterial thrombosis is the fourth cause of sudden arterial occlusion. This is not commonly recognized or described but undoubtedly is a true entity. Cyanosis develops distally first and progresses centrally to thigh and hips without the presence of an embolus. The lack of edema and less severe pain differentiate it from phlegmasia cerulea dolens. It commonly occurs in elderly people who are dehydrated, commonly in cardiac decompensation, and frequently hypotensive. They often have been treated for hypertension and now have a normal blood pressure, which is inadequate for them. Sometimes they have become hypovolemic and hypotensive, requiring treatment with vasopressor drugs. In any case, they have an inadequate peripheral circulation which is insufficiently active to keep the blood from clotting.

It is amazing how hydration and elevation of the blood pressure can reverse the loss of pulse or halt the progression of cyanosis. Usually, in spite of all effort,

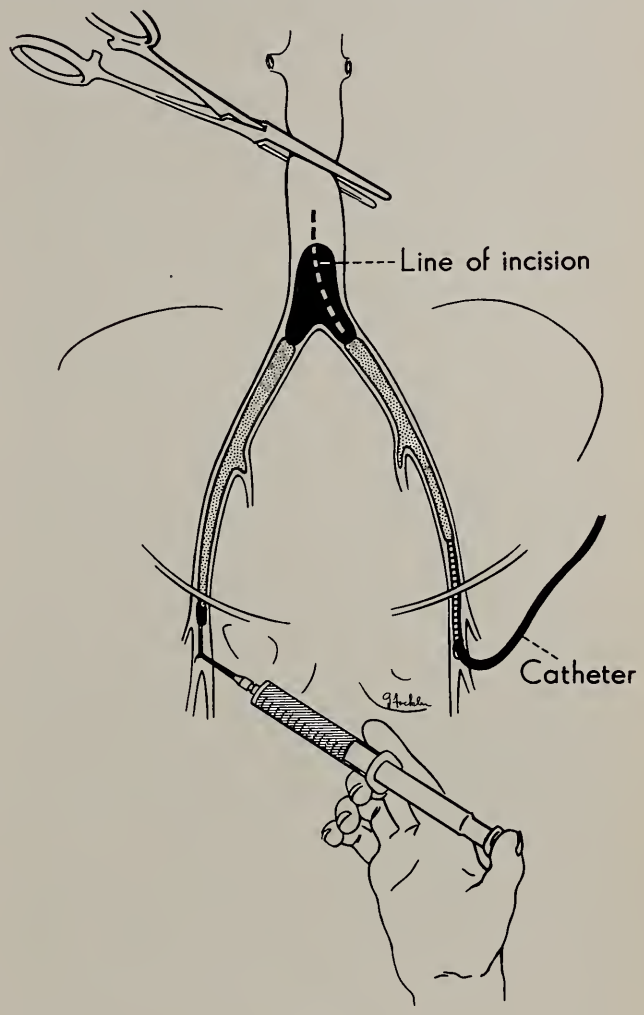


Fig. 1.

the thrombosis progresses from feet to calves, thighs and often the buttocks before death ensues. This type of circulatory insufficiency probably accounts for some cases in which there is thrombosis of the superior mesenteric artery. Prognosis is very poor. Surgery is hopeless. Fluids to increase circulatory volume and blood pressure with the use of anticoagulants are most helpful.

Thrombosis of an aneurysm,[3] or embolization from an aneurysm, when it does occur, is more likely to develop in conjunction with the peripheral aneurysm. It is a frequent complication of popliteal aneurysm. Trauma may be the precipitating cause. Commonly, these are recurrent episodes of small, minor distal emboli prior to the major extrusion of aneurysmal

clot. Removal of the aneurysm and distal clot, with placement of a graft may be curative. Care must be taken not to place the graft under tension.

Phlegmasia cerulea dolens[4] must be included in a differential diagnosis of acute arterial occlusion. This is a serious form of fulminating thrombophlebitis involving both veins and arteries. It is characterized by the rapid onset of severe pain, tense edema and a purple discoloration of the leg. The foot becomes cold and pulses may disappear. Clots will be found in the veins as well as in the arteries. A lumbar sympathetic block and anticoagulants are indicated. On occasion, the venous clots have been removed. The prognosis for both limb and life are very poor.

Non-surgical Care.—In the case of sudden arterial occlusion which cannot be helped by removal of an embolus, certain other methods are indicated. Anticoagulants[5] will often help a marginal foot or arm to survive. After prolonged use, circulation gradually increases by development of collateral. Heparin appears to be most effective. However, one must use coumadin or dicumarol when prolonged therapy is indicated. In the marginal recovery, prolonged therapy is a necessary procedure; but, it must not start for two to four days following surgery because of almost certain hematoma formation. Early use of 50 mgm of heparin intravenously each night seems to be a safe way to start anticoagulants. At this time the patient is quiet and least likely to bleed.

Sympathectomy is indicated in the marginal case, although the results cannot be dramatic. Desludging agents, such as Plaquenil[6] should be considered. These are antimalarial drugs which in theory reduce the tendency of cells to stick to each other where the flow is slow and pressure low. Cells which stick together, do not freely enter cell diameter capillaries. Fibrinolysin[7] is a new agent used to help reduce the formation of distal clotting and to help reabsorb the already formed clot. Where surgical removal is impossible, as in small vessels of the kidney, heart, and brain, or in extremely moribund individuals, these methods can be helpful.

Discussion

The prognosis for the extremity is excellent with the true embolus which is totally removed. Recovery from the ischemic paralysis occurs first. Commonly, the sensory changes do not disappear even with a pedal pulse present for two to four days. Recurrent emboli, when they do recur, frequently lodge at the original site and do not usually represent a defect in the arteriotomy closure. We have seen people with as many as four separate emboli to different sites survive and do well. Repeated operations in a single area are prone to infection; and this is bad at an arteriotomy site.

Anticoagulants are important in decreasing recurrences of emboli. Without anticoagulants, 30 to 50 per cent will have a recurrent embolus. Prognosis for life is excellent in the patient with a thrombosis beyond a chronic block, but survival of limb is not so good as with an embolus. It is often necessary for these people to take anticoagulants for life in order to ensure survival of the extremity.

In the occasional case of occlusion due to a dissecting aneurysm, recovery and prognosis is guarded and depends on spontaneous or operative re-entry which to date is a less common procedure. Success is extremely poor with distal agonal thrombosis.

Summary

Sudden arterial occlusion is not always due to an embolus, but may be due to a thrombosis distal to a chronic segmental arterial block, a dissecting aneurysm, distal agonal thrombosis, an arteriosclerotic aneurysm or phlegmasia cerulea dolens. A differentiation of cause is important for predicting prognosis and indicating the proper surgical approach. Temporary use of heparin is indicated to prevent progression of distal thrombosis until emergency surgery can be accomplished, postoperative anticoagulants are important in minimizing reformation of an embolus.

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Posterior Myocardial Infarction

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"Rose is a rose is a rose is a rose"

From "Sacred Emily" by Gertrude Stein †

IN PLANNING treatment of an acute myocardial infarction, it is rare to find anyone giving much thought to its anatomic location. Even though the high incidence of heart block in acute posterior infarctions was recognized many years ago,[1,2] most modern textbooks on cardiology[3,4] barely mention this point. Heart block as a feature of acute posterior infarction is more than an academic curiosity. It affects diagnosis, prognosis and treatment, and an understanding of its pathogenesis is thus essential to all three of these cardinal principles of patient care.

The unique features of acute posterior myocardial infarction may be discussed under three headings: anatomy and pathophysiology, clinical features, and clinical management.

Anatomy and Pathophysiology

Recent editorials have reminded us that in most myocardial infarctions more than one coronary artery is extensively diseased, and that the concept of "transmural" infarctions is rarely supported in fact, most infarctions being streaky or lamellar.[5,6] Even so, the clinical behavior of this disease can best be understood by considering a discrete area of infarction due to a single coronary occlusion. When we understand the simpler infarcts, we can more reasonably expect to unravel the perplexity of the more complex ones.

Posterior myocardial infarctions are those which involve the diaphragmatic surface of the heart, most commonly near the crux (Fig. 1), and are manifested by primary electrocardiographic changes in leads II, III and aVf. Since the artery supplying the crux also supplies the atrioventricular node, occlusion of this artery frequently produces heart block. In man, the crux of the heart is supplied by the right coronary artery about 90 per cent of the time.[7-10]

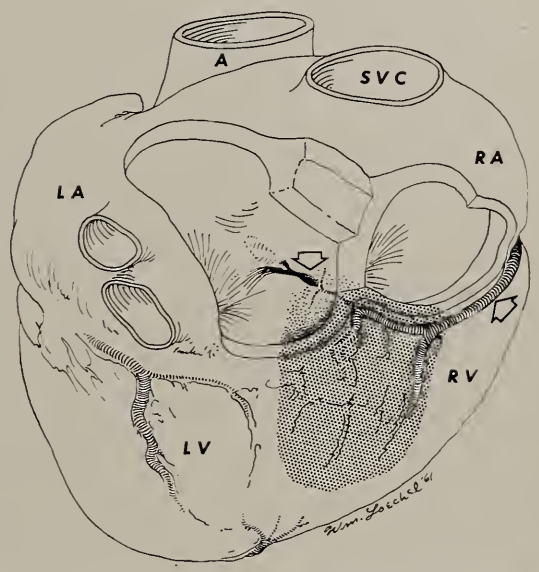


Fig. 1. A view of the posterior surface of the human heart from the left and above. LA is left atrium, RA right atrium, LV left ventricle, RV right ventricle, A aorta and SVC the superior vena cava; portions of the posterior wall of the left and right atria have been cut away, along with the posterior part of the interatrial septum, to allow visualization of the A-V node (left arrow). Occlusion of the right coronary artery (right arrow) produces an infarction in the stippled area and includes the A-V node. This is at the crux of the heart, the point at which the atrioventricular sulci cross a line along the posterior margins of the interatrial and interventricular septa.

A recent study demonstrated that atrial arrhythmias beginning during acute myocardial infarction were associated with coronary occlusions proximal to the blood supply of *both* the sinus node and A-V node, and that the sinus node was always infarcted.[11,12] It is significant that in each case the blood supply to both

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† There's a notable family called Stein:
There's Gertrude, there's Ep, and there's Ein.
Gert's writings are punk,
Ep's statues are junk,
And nobody understands Ein.
From "Stein Song" (Anon.)

of these efficient pacemakers of the heart was compromised. Thus patients with infarction at the crux of the heart not only jeopardize A-V conduction, but they also become more prone to a disorganized cardiac rhythm—in the event the sinus node should fail—because of the removal of an efficient alternate pacemaker (the A-V node).

When posterior infarctions are due to right coronary occlusion and the left circumflex and left anterior descending coronary arteries are patent, optimal opportunity exists for collateral circulation to the ischemic area. Thus posterior infarction may involve a relatively small mass of myocardium, but its inclusion of the blood supply to the A-V node may result in profound clinical changes.

Morphologic studies of the myocardium and the coronary arteries in myocardial infarction were commoner years ago than they are now. Much of our present knowledge is based on three-lead electrocardiograms. Valuable as these studies were, many infarctions of various sizes were missed. Additionally, our knowledge of the true incidence of rhythm and conduction disturbances during acute myocardial infarction is limited by the infrequency of electrocardiograms during the acute phase of the illness. Tracings more frequent than once or twice a week, particularly when supplemented by careful clinical examination, are probably not necessary in the clinical management of the routine acute myocardial infarction. Despite this practical consideration, it must be conceded that significant changes in cardiac rhythm and conduction often escape detection, and that our information is therefore incomplete.

In more than fifty hearts from patients with heart block, which I have dissected with particular attention to the blood supply of the sinus node and A-V node, there was always a morphologic reason for occurrence of the heart block. When this was a vascular lesion, it was always an occlusion of the coronary artery supplying the A-V node. If heart block occurred during an acute anterior infarction, there was always an associated old or new posterior infarction, sometimes not recognized clinically. A "functional" suppression of A-V conduction by excessive vagal discharge can occur transiently during acute infarction, but even this may be commoner in posterior infarcts.

Anatomic reasons for the frequency of rhythm and conduction disturbances in acute posterior infarcts have been discussed above. The commonest supraventricular arrhythmia is atrial fibrillation.[3,13] Atrial fibrillation is usually transient (and often escapes detection), but when sustained it is associated with a much increased mortality.[13] One reason for this is the inability of the infarcted ventricle to compensate (during rapid rates) with either more rapid diastolic filling or accelerated systolic ejection, and cardiac output falls. The gravity of a rapid ventricular rate in myocardial infarction should not be confused by data on cardiac output in rapid ventricular rates without myocardial infarction, since the intact ventricle is able to maintain its output near normal.[14,16] The cardiac output decreases with bradycardia during heart block for similar reasons; the normal heart at slow rates maintains cardiac output by increasing stroke volume, but the infarcted ventricle cannot do this.

Clinical Features

Loss of consciousness during acute posterior infarction is due to heart block, reduced cardiac output and cerebral ischemia. In patients with cerebral atherosclerosis, these symptoms are usually more severe and may lead to hemiparesis. Transient syncope is often interpreted by the patient as a visual disturbance and unless specifically questioned he may forget this.

Variable periods of unconsciousness during acute posterior infarction are commoner than generally realized. Regular close questioning about this symptom in patients with acute posterior infarcts is quickly impressive. Just as syncope or convulsions must be watched for in acute posterior infarction, acute posterior infarction must be considered in any patient having otherwise unexplained syncope or convulsions.

Dizziness or syncope is commonly a part of the premonitory phase of posterior infarction, sometimes recurring for months or even years. Such cases are occasionally considered primary neurological disorders and are sometimes even dismissed as being psychogenic. Syncope may be the only expression of "angina," but more often there is a preceding or concomitant period of chest pain. Unless the patient is specially questioned, however, he may be more impressed by the cerebral symptoms and fail to mention the chest pain.

Increased vagal activity is observed in most patients with acute myocardial infarction,[17] but is particularly present in acute posterior infarcts. It contributes to likelihood of both arrhythmias and heart block. Sialorrhea, diaphoresis, marked sinus bradycardia, tenesmus, nausea and vomiting have all been more frequent in posterior than anterior infarctions, in my experience.

Since heart block in posterior infarction is due primarily to ischemia of the A-V node, other evidence of A-V node ischemia also occurs. This includes pre-

mature A-V nodal beats, Wenckebach phenomenon (which may be misinterpreted on auscultation as premature beats), and aberration of A-V conduction with Wolff-Parkinson-White complexes.[10] In 2:1 heart block, misinterpretation of the regular auscultatory rhythm may be avoided by inspection of the neck veins, which will usually reveal an atrial rate double that of the ventricles.

Heart block may first appear immediately at the onset of pain, or at any time in the first few days after an acute posterior infarction. Vagal hyperactivity is an important early contributory factor, but heart block several days later probably represents ischemic necrosis of the A-V node or bundle. During complications at any time in the course of a patient with acute posterior infarction, the possibility of heart block must be anticipated. This is particularly true of states reducing arterial oxygen saturation such as congestive failure or pneumonia or anemia (e.g., blood loss due to excessive anticoagulation), and heart block may appear then, whereas it did not (or was not recognized) earlier.

Because arrhythmias and heart block are commoner in acute posterior myocardial infarction, and since both of these are associated with reduction in cardiac output, the initial course of the patient with posterior infarction is inclined to be more stormy and sudden death more common. Conversely, the ultimate prognosis of these patients is better than with some other myocardial infarctions, since the loss of myocardium at the crux is often relatively small.

The exact differential mortality of acute anterior and posterior myocardial infarcts is not really known. The onset of an acute infarction with heart block must be associated with an extremely high immediate mortality, and an undetermined number of such patients die at home or on the street, seldom reaching the statistical analyses of mortality in acute myocardial infarction.

Clinical Management

It is the involvement of the A-V node which determines the special aspects of treatment for the patient with an acute posterior infarction. Since A-V block may appear at any time within the first few days following the onset of the infarction, closer observation and more frequent electrocardiograms are indicated. The availability of an external defibrillator and cardiac pacemaker are desirable in any myocardial infarction, but their necessity is more frequent in acute posterior infarction. The onset of heart block or arrhythmias is often preceded by a fall in blood pressure. The value of pressor amines in such situations is well established, and their use may terminate the rhythm or conduction disturbance by restoring the efficiency of the collateral circulation.[15,16] In essence, one employs the same emergency measures as for any myocardial infarction, but their necessity is more frequent with acute posterior infarctions.

Straining for a bowel movement is associated with increased vagal tone which may lead to heart block, and is thus particularly to be avoided in patients with posterior infarcts. A similar modified Valsalva maneuver occurs when the patient is asked to hold his breath during the recording of certain electrocardiographic leads (a common practice for the evaluation of Q waves in lead III), and breath-holding for this purpose should not be used in the patient with posterior infarction.

Drugs affecting A-V conduction include digitalis, quinidine, morphine, procaine amide and barbiturates. If congestive failure develops during acute posterior infarction, digitalis may still be used, but its depressant action on A-V conduction must be kept in mind. Its use, then, becomes a calculated risk, in which the dangers of the heart failure may outweigh the risk of inducing heart block.

There is no more effective medication for the pain of acute myocardial infarction than morphine. It is vagomimetic, however, and produces vomiting and constipation in many patients. An effective remedy for this problem is to employ atropine routinely with any dose of morphine (1/150 grain of atropine sulfate for 1/4 grain of morphine sulfate). The vagolytic effect of the atropine is seldom a problem when used in conjunction with the vagomimetic effect of morphine. During acute heart block or intense sinus bradycardia considered to be due to excess vagal tone, it may be necessary to employ atropine alone, a common practice of anesthesiologists who encounter vagal reactions. In a patient with an infarcted ventricle the hazard is different, but the risk is often still justified.

Some recommend the routine use of quinidine for the suppression of myocardial irritability during acute myocardial infarction,[4,18] while others advise against this as routine practice.[3] Whether indicated in anterior myocardial infarctions or not, quinidine is hazardous in patients with acute posterior infarction. Its generalized suppression of myocardial excitability[19] does not spare the A-V node, where conduction is already jeopardized. In posterior infarction, a few premature beats are better watched cautiously, rather

than to enhance unnecessarily the likelihood of heart block.

Barbiturates are so commonly employed in the management of many illnesses that their action suppressing myocardial excitability[20,21] is often forgotten. Though their myocardial depressant action is relatively minor if compared to quinidine in conventionally employed doses, excessive use of barbiturates is unadvisable in acute posterior infarction because of the possibility of enhancing the development of heart block.

Summary

Heart block has long been recognized as a feature of acute posterior myocardial infarction. Despite this, many physicians stereotype their thinking on the clinical management of acute myocardial infarction, and make no special distinction for posterior infarction. The clinical importance of making such a distinction is discussed, as well as those measures which contribute to the optimal management of the patient.

"A rose is a rose is a rose, and a caterpillar is a tractor."

From "Others in the Cast Include," by Ogden Nash.

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On Professional Spirit . . .

While the good physician has humility, he also has a *pride* in his service to humanity. While he is willing to make personal sacrifice, he is *unwilling* to sacrifice quality and integrity. And while he is dedicated to his profession, he also is *aware* of the part which he must play in the world around him.

In these comments on the professional spirit, I have, of course, been discussing an ideal. Probably few of us, past or present, have realized this ideal completely, or perfectly, or at all times. The doctor, being human, sometimes falters, stumbles, or is frustrated by demands and misunderstandings. But the true physician always continues the search and the striving—and therein lies the stimulating, creative value of the medical life.—LEONARD W. LARSON, M.D., AMA President, Inaugural Address.

The Pulmonary Capillary Bed in Cardiac Disease

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ALL OF THE OXYGEN used in metabolism is absorbed by the pulmonary capillary bed and virtually all the carbon dioxide produced is excreted through this bed. The capillary circulation of the lung is thus vital to the economy of the body. Its function can be affected by either cardiac or pulmonary disease. Study of this bed is, therefore, important in learning the ways in which diseases of these organs affect the body.

One approach to the study of the capillary bed is, visually, with a microscope. Such a study is unexcelled for observing the reactions of the individual vessels and in this way the large reserve capacity of the pulmonary capillary bed and the intermittent circulation in any given capillary have been established.[1,2] A study of the mesenteric circulation[3] has led to the concept that the capillary bed consists of certain relatively direct channels between artery and vein from which the true capillaries arise by lateral branching. In this bed the origins of the true capillaries from the thoroughfare channels are surrounded by a cuff of smooth muscle (precapillary sphincter). There is good evidence[4] that the true capillaries neither constrict nor dilate but that they either close or open fully and that a key factor determining patency is the tone of the precapillary sphincter.

Direct observation, however, cannot be made in man or under physiological conditions even in experimental animals. Further, direct observation gives only a qualitative notion of the volume of blood in the capillaries or the rate of flow in these vessels.

Recently, indirect methods have become available which permit study of the pulmonary capillary bed in man, which give quantitative values for capillary volume and capillary flow, which permit deductions as to the patency of the capillaries and which, moreover, give data relating to the whole capillary bed of the lungs rather than to an individual microscopic field.

The purposes of this paper are to outline the indirect methods available for study of the pulmonary capillary bed, summarize the results obtained in normal subjects under various physiologic conditions, and describe some observations made in patients with disease involving this vascular bed.

Methods

The first estimate of the blood volume of the pulmonary capillary bed was made by Roughton[5] and this work was extended by Roughton and Forster.[6] This method rests on the fact that the reaction of carbon monoxide with hemoglobin proceeds at a measurable rate and that this rate is a function of the tension of oxygen present, being less with high tensions of oxygen. Thus, at a given oxygen tension, and hence reaction rate, the rapidity with which the lungs take up carbon monoxide is determined by the volume of blood available in the capillaries to react with carbon monoxide. The rapidity of uptake of carbon monoxide by the lungs is simply the pulmonary diffusing capacity for carbon monoxide (DL_{CO}).

Thus, if the DL_{CO} is measured at several reaction rates (corresponding to several oxygen tensions), it is possible to calculate the capillary blood volume (V_c). To do this it is necessary to convert both DL_{CO} and reaction rate to their reciprocals since in this form these quantities represent resistances and, like electrical resistances, can be added. When such data are plotted, a straight line similar to Figure 1 is obtained. The slope of this line is the reciprocal of the capillary volume (V_c).

Note that this line crosses the vertical axis above zero. A zero value for the reciprocal of the reaction rate represents an instantaneous reaction of carbon monoxide in hemoglobin. The distance between the intercept and zero on the vertical axis represents the resistance to the uptake of carbon monoxide imposed by the surface area and thickness of the membrane which separates the carbon monoxide in the alveoli from the hemoglobin in the capillaries. It is thus a measure of the membrane diffusing capacity (D_m).

Since the D_m is a function of both the area of the capillary wall in contact with the alveoli and the thickness of this wall, changes in this value are somewhat difficult to interpret. For example, an increase in membrane diffusing capacity could be due to an in-

crease in surface area or to a decrease in wall thickness or to both processes.

Here another recently developed technique may give important information. It is the measurement of pulmonary tissue volume (V_t) devised by Cander and

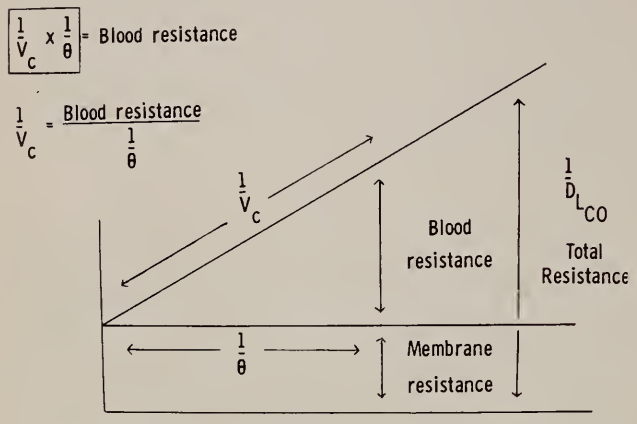


Fig. 1. Graphic determination of capillary volume (V_c) and membrane diffusing capacity (D_m). The reciprocal of diffusing capacity ($1/DL_{CO}$) is plotted against the reciprocal of reaction rate ($1/\Theta$). The slope of this line is the reciprocal of capillary volume ($1/V_c$). The intercept of this line on the vertical axis is the reciprocal of membrane diffusing capacity or membrane resistance. This figure appeared in the *Journal of Clinical Investigation* (37:1061, 1958) and is reprinted by permission.

Forster.[7] The principle involved here is that after a very soluble gas like acetylene is inhaled its concentration falls for three reasons: (1) it is diluted in the gas already present in the lungs; (2) it dissolves in the tissue of the lungs; (3) it is carried away by the blood flow. The amount of dilution is easily measured by inhaling at the same time a poorly soluble gas like helium. Both helium and acetylene are diluted to the same extent. The amount dissolved in tissue is separated from that carried away by the blood by the fact that solution in the lung is very rapid while blood flow is a continuing process.

The actual measurement involves determining the dilution of acetylene relative to helium at several times and plotting the results against time. Thus, the amount of gas dissolving in the lung tissue can be separated from that dissolved by the blood and values for both tissue volume (V_t) and blood flow (Q_c) obtained. We[8] have modified the technique described by Cander and Forster by using rebreathing rather than periods of breath holding.

The measurement of V_t enables one to interpret changes in D_m more readily, since changes in tissue volume should be related to changes in the amount of tissue (or fluid) through which gas must pass from alveolus to capillary. For example, if the increase in D_m discussed here is accompanied by a decrease in V_t, it is probably due to a decrease in the distance that gas must travel rather than to an increase in surface area.

The measurement of tissue volume also has obvious usefulness in studying the accumulation of fluid in the lungs in congestive heart failure and its relation to symptoms in such patients.

Normal Values and Physiological Changes

In their original report, Roughton and Forster[6] report data on seven normal subjects. Subsequently, we[9] reported data on nineteen normal subjects. McNeill, Rankin and Forster[10] reported data on eight normal subjects. Bates and associates[11] studied fourteen normal subjects during moderate exercise. These data are summarized in Table I. It will be noted that, while the values reported are of the same order of magnitude, the range of values is fairly wide. We[9] have considered possible reasons for these differences and concluded that the values obtained are more valuable for indicating changes in these parameters or deviations from normal, than as absolute values.

We[9,12] studied changes in V_c and D_m under various conditions. The results of our study are summarized in qualitative form in Table II. We have been particularly interested in the factors that regulate the pulmonary capillary bed and have, therefore, attempted to correlate the changes observed with available data on the changes in pulmonary artery and pulmonary venous pressure in these circumstances. From such changes, we have deduced the change in capillary transmural pressure (TMP) that might be expected under these circumstances. From data such as that in Table II we feel that the TMP controls the volume of blood in the capillaries; that is, in most situations the capillary bed passively responds to events elsewhere in the cardiovascular system that control TMP. An exception to this is the action of norepinephrine; it will be noted that although capillary pressure is increased in this condition capillary volume does not increase. A possible explanation is that norepinephrine constricts the cuff of smooth muscle at the junction of the true capillary with the thoroughfare channel and thus prevents an increase of blood volume in the capillaries.

Table II also reveals a possible explanation of the changes in D_m observed. At least a part of the thickness of the membrane between alveolus and capillary is made up of the interstitial fluid of the lung. A lowered TMP should lead to reabsorption of this fluid

in accordance with the Starling hypothesis. This would decrease the membrane thickness, and if not accompanied by a decrease in V_c, would give an increase in D_m. Since V_c decreases in this situation, the net result might be an unchanged D_m.

In diffuse pulmonary fibrosis due to a variety of causes, the published work of Bates et al[11] and McNeill, Rankin and Forster[10] indicates a low V_c and D_m. Our own experience is similar.

In obstructive emphysema, McNeill, Rankin and Forster[10] found a normal V_c and a moderately low D_m in three cases. In fourteen emphysema patients, we have also found a low D_m, but frequently a low V_c as well. No studies on cor pulmonale in emphysema patients are as yet available.

TABLE I. V_c AND D_m IN NORMAL SUBJECTS*

Condition	Subjects	DLco Method	Vc ml	Dm ml/mm Hg x min.	Reference
Seated	7	Single breath	78.7	57.6	6
Seated	19	Single breath	65.0	98.1	9
Seated	8	Single breath	97.3	63.5	10
45° tilt	7	Rebreathing	110.0	48.0	12
Exercise	14	Steady state	143.0	50.8	11

*Abbreviations: Vc, capillary blood volume; Dm, membrane diffusing capacity; DLco, diffusing capacity of the lungs for CO.

For this reason, we have been greatly interested in measurements of V_t. For this measurement we[8] have developed a rebreathing method and have obtained results in normal subjects that compare with those obtained by Cander and Forster[7] with the single breath method they originally described. In four subjects we have found a decrease in V_t when changing from the recumbent to the upright position.

Clinical Studies

McNeill, Rankin and Forster[10] and Bates and associates[11] have found elevated V_c and low D_m in mitral stenosis during failure. After valvulotomy one of the patients of Bates and his co-workers[11] showed a considerable decrease in V_c and a moderate increase in D_m.

Our experience in a patient with cardiac failure from essential hypertension is similar and is shown in Figure 2, in which the abnormality and the improvement with therapy can be seen.

In primary pulmonary hypertension, Bates and his group[11] and we have found decreases in both V_c and D_m.

Future Usefulness

The study of the pulmonary capillary bed has thus far been concerned with the development of methods, some elucidation of physiological changes in this capillary bed, and a variety of studies on patients who while having the same diagnosis may have a wide range of cardiovascular abnormalities.

Many questions remain unanswered, particularly in regard to control of the pulmonary capillary bed. We have found that norepinephrine prevents an increase in V_c when TMP is increased and, in this sense, is a capillary vasoconstrictor. Are there other such substances? Is capillary vasoconstriction a part of the body's defense against pulmonary edema? Are there capillary vasodilators? Do these substances affect capillary permeability as well?

TABLE II. RELATION OF V_c AND D_m TO HEMODYNAMIC CHANGES*

Position	Procedure	PAP	CO	PCP	PVR	TMP	Vc	Dm	Reference
Tilted	None	↓	↓	↓	↑	↓	↓	0	13
Recumbent	Trimethapan	↓	↓	↓	0	↓	↓	0	14, 15
Tilted	Trimethapan	↓↓	↓↓			↓↓	↓↓	0	16
Recumbent	Exercise	↑	↑	0	0	↑	↑	↑	9, 17
Recumbent	Norepinephrine	↑	0	↑	?	↑	0	↑	18, 19
Tilted	Norepinephrine		0			↑	0	0	20

*Abbreviations: PAP, pulmonary artery pressure; CO, cardiac output; PCP, pulmonary "capillary" (or wedge) pressure; PVR, pulmonary vascular resistance; TMP, deduced trans-mural pressure in capillaries; blank, no data; ?, conflicting results. Arrows indicate direction of change from recumbent position, no drug administered. This table appeared in the J. Clin. Invest. *39*:1345, 1960 and is reprinted by permission.

In patients with increased pulmonary blood flow due to intracardiac shunts and to thyrotoxicosis Bates and associates[11] did not find any increase in V_c although McNeill, Rankin and Forster[10] did. The former studies, however, were done during exercise.

The capillary bed is restricted in primary pulmonary hypertension, in emphysema, and in diffuse fibrosis. Is the occurrence of pulmonary hypertension in these diseases due to restriction of the pulmonary capillary bed or do both the pulmonary hypertension

and the restricted capillary bed result from narrowing of the arterioles? What changes occur in the capillary bed when cor pulmonale develops in these diseases?

The ebb and flow of pulmonary tissue volume with change of position opens further areas for investiga-

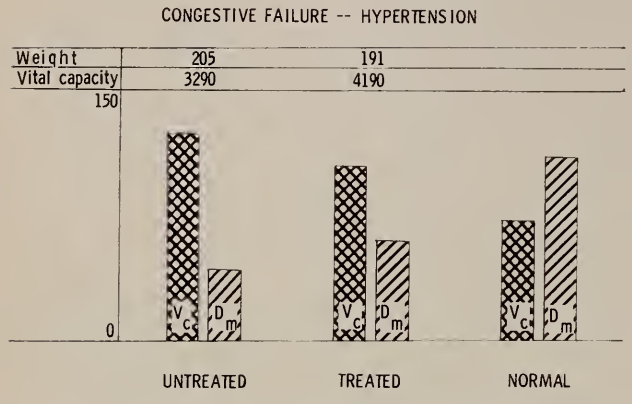


Fig. 2. V_c and D_m in congestive heart failure. Measurements of V_c and D_m in a patient with failure due to hypertension before therapy (left) and after therapy (center) are contrasted with normal values (right). Change in vital capacity and body weight with treatment are shown at the top. The scale at left applies to both V_c and D_m and the units are ml for V_c and ml/mm Hg x min. for D_m.

tion. How much fluid must be deposited in the lungs before the patient becomes dyspneic? Is this related to increased stiffness of the lungs? How much fluid can be mobilized from the lungs by the therapy of pulmonary edema?

The study of the pulmonary capillary bed has progressed to the point where correlated investigation of flow through the lungs, the pressures in the pulmonary artery and pulmonary veins combined with the methods discussed in this paper can attempt to answer such questions.

Acknowledgments

Research from the Pulmonary Function Laboratory, Wayne State University, cited in this paper was supported by grants from the Michigan Heart Association, National Heart Institute (H 2379) and the Receiving Hospital Research Corporation.

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Experimental Study of Apical-Aortic Anastomosis for Aortic Stenosis

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THE SURGICAL APPROACH to aortic stenosis has been improved by the use of the pump oxygenator, however, the results have not been as gratifying as in mitral stenosis due, largely, to the actual pathology found at exploration. We, like others, have been impressed that the aortic valve when diseased would be best handled by the replacement of the valve by some adequate aortic prosthesis. Still there is a large group of patients who, we believe, could not be benefited even by a direct approach to the valve due to their age or general debilitated conditions. It was this group of patients that stimulated us to investigate some method of surgically relieving the deleterious effects of aortic stenosis.

In 1955, Dr. Sarnoff[1] suggested and experimentally produced a group of dogs in which a new passage for the outflow of blood from the left ventricle was vented from the apex of the heart. This in combination with a tube anastomosis to the descending thoracic aorta in a Hufnagel-type valve proved successful in a number of animals. Under the present day improvement in prosthetic grafts, we decided to re-study this approach of apical egress of blood from the left ventricle and see if the technical, as well as the physiological effects might possibly be adequate to consider it for clinical use.

Method

A group of mongrel dogs weighing between 10 and 15 kilos were used for this experimental study. These could be grouped into three series, due to the continual modification of the technique until a technique was devised that gave long-term survivals.

Group one consisted of an apical anastomosis between the apex of the left ventricle and the aorta with a Hufnagel valve interposed in its mid portion. Group two—the technique was modified in that the Hufnagel valve was placed at the apex of the heart

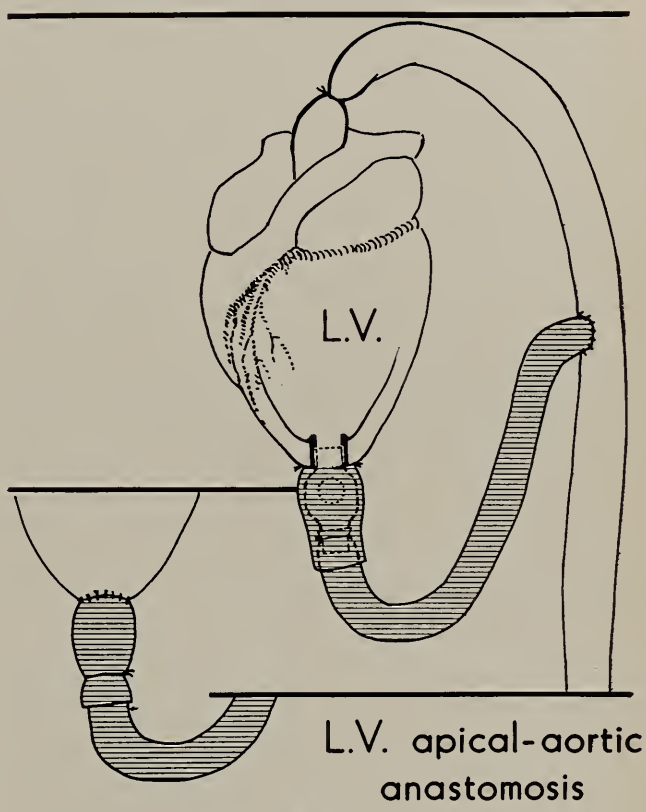


Fig. 1.

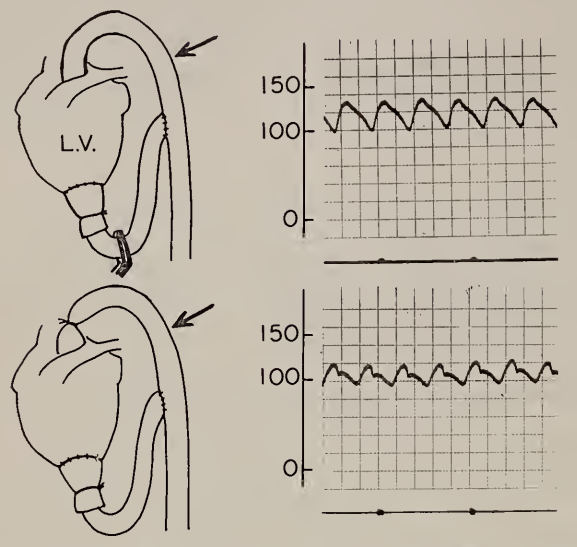
encased in a sleeve of graft and then a separate segment of graft was run from the Hufnagel valve to the descending thoracic aorta. Group three consisted of the present long-term series in which the Hufnagel valve was glued to a holekeeper from which ran a graft down to the descending thoracic aorta anastomosed end to side (Fig. 1). In all the dogs, the pressure relationship between the left ventricular pressure and the aortic pressure was obtained at the time of surgery after the ascending aorta had been ligated

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Presented at the 9th Annual Meeting of the Michigan Chapter of the American College of Surgeons, Detroit, March, 1961.

about 1 cm. to 1.5 cm. above the takeoff of the coronary vessels.

In a group of two acute experiments, after the technique had been solidified, the coronary sinus was



Hemodynamics of apical outflow operation

Fig. 2.

cannulated and relative coronary flows were obtained; in these two animals, each acting as its own control, with and without the ascending aorta ligated and the apical-aortic anastomosis functioning.

Results

The first two groups of animals can be roughly classified as failures due largely to two complications. In the first group, the actual hole in the apex of the left ventricle to allow the egress of the blood, was found to be difficult to accomplish and a punch was devised in which a cross sectional area measuring 1 cm. in diameter or 1.8 sq. cm. in area could be punched out of the apex of the heart.

In group two, even though the actual area was punched out, it was found that on contraction of the left ventricle, a stenosis occurred at the new aortic ostia. The Hufnagel valve which was pressed against the apex of the heart caused necrosis and sloughing of the grafted area with fatal hemorrhage.

In group three, there are actually two groups because a polyethylene and, later, a nylon holekeeper were derived to hold open the punched out exit from the left ventricle. The first type of holekeeper was a straight tube measuring 1 cm. inside diameter which led to stenosis on the development of granulations which flowed over the inside of the holekeeper and occluded the lumen. This complication was negated by adding a phlange to the holekeeper. Two types of phlanges were devised; one solid and one pliable, glued to a tube of nylon which, in the chronic preparation, has satisfactorily controlled the development of granulations and resultant stenosis of the ostia. On measuring the pressures in the left ventricle and in the descending thoracic aorta with the ascending aorta ligated, it was found that a pressure drop ranging from 10 to 15 mm./Hg. was generated by the development of this type of anastomosis (Fig. 2). This was not considered pathological and the four chronic animals that survived have gone as long as three months and seem to have an excellent exercise tolerance and an ability to survive this procedure chronically. In the four animals in which the acute coronary flow was measured from a relative flow approach, each animal acting as its own control, the coronary flows were found to increase by ligation of the ascending aorta with the apical-aortic anastomosis functioning.

Discussion

This is obviously too early to make any definite conclusions as to the merit of this procedure. However, the actual fact that animals can survive this type of anastomosis and the known fact that in humans we, as well as Dr. Hufnagel have had Hufnagel valves in place up to seven years, leads one to believe that, perhaps, this may be an applicable method in that group of patients in which total body perfusion is dangerous or the risk too high to assume for the open repair of their aortic stenosis. There are obviously a number of studies still to be carried out, i.e., red cell survival which in Dr. Sarnoff's animals showed deterioration due to the abnormal egress of blood and the action of a ball-valve prosthesis. We believe that an end to side aortic apical anastomosis is a much more satisfactory and easier technical anastomosis than the cumbersome method of Dr. Sarnoff. The development of a granulating stenosis of the ostia of the apical anastomosis seems to be satisfactorily controlled by the phlanged holekeeper. However, only chronic preparations of a number of years will actually tell us whether this is a true fact or not. Renal functions, as well as the possible embolization distally which has always been a troublesome complication of Hufnagel valves will have to stand the test of time and examination of kidneys as well as mesentery. It has been our unfortunate experience that dogs are not an excellent animal for the study of arterial embolization since

they appear to be able to sustain arterial embolization much better than humans.

There were some animals in the chronic group that died unexplained, even after post mortem examination, and these were considered to have died of acute coronary insufficiency. However, the two preparations testing the relative coronary flow with and without the ascending aorta ligated and the apical-aortic anastomosis in place, seemed to refute this contention that these animals died of coronary insufficiency.

Summary

This is an experimental study of physiological pressure relations, coronary flows, and modified technical changes necessary for the successful production of long-term survival in a series of experimental animals (dogs) with an apical-aortic valvular anastomosis as suggested by Sarnoff.

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Biopsy Apparatus Developed

Doctors at the University of Michigan Medical Center have developed a new bite-size apparatus that will take tiny samples of living tissue from a patient's small intestine without surgery. Its use may cut down the need for exploratory operations in suspected stomach cancer and other disorders of the digestive system.

The instrument is called a "hydraulic biopsy apparatus." Attached to a length of soft plastic tubing is a stainless steel capsule smaller than a piece of rock candy, which is swallowed by the patient.

Inside the capsule is a razor sharp cylinder that is activated by hydraulic pressure transmitted down the plastic tube. On each motion, it crosses a small opening in the capsule and slices off a microscopic layer of the lining of the intestine.

The sample is then washed up through the plastic tube so it can be analyzed by the attending physician. Any number of tissue samples can be taken before the capsule is removed.

Robert J. Bolt, M.D., and Arthur B. French, M.D., both associate professors of internal medicine at the University of Michigan began developing the apparatus two years ago.

New Branch of Medical Science?

Add to your medical vocabulary a new term—"propetology."

Roger J. Williams, Ph.D., and Frank L. Siegel, Ph.D., Clayton Foundation Biochemical Institute, University of Texas, suggest this term for a new science "which will deal with innate susceptibility and resistance primarily to diseases of a noninfective nature."

Many diseases have genetic roots. The term, taken from the Greek propet, "leaning toward," emphasizes that people "merely lean toward certain diseases; it is by no means inevitable that they will contract them."

People who are prone to certain diseases "would not need to suffer from these diseases if their proneness were recognized early and if appropriate measures could be taken to overcome it."—*American Journal of Medicine*, September, 1961.

Anti-Hypertensive Effects of Chlorothiazide Reserpine and Placebo

A *Double-Blind Evaluation*

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IT IS generally agreed that the best control in evaluating a new medication is achieved by utilizing the double-blind technique. The double-blind technique is of particular value in assessing anti-hypertensive agents to minimize the variations intrinsic to essential hypertension and those due to emotional ties between physician and patient. Effects of phenobarbital,[4,13] rauwolfia alkaloids,[2,4,9,10,13,14] and hydralazine[10] have been evaluated in this manner.

Since its synthesis by Novello and Sprague in 1957, chlorothiazide has had intensive clinical trial as an anti-hypertensive and diuretic agent. Numerous published reports have compared the effects of chlorothiazide with other anti-hypertensive agents. To our knowledge, there has been no published evaluation of the anti-hypertensive effect of chlorothiazide, utilizing the double-blind technique. We have hoped to assess, as objectively as possible, the anti-hypertensive effect of chlorothiazide and its combination with reserpine.

Method

Eighteen hypertensive patients from the outpatient clinic of Detroit Receiving Hospital completed the study and were used in the evaluation. The study was undertaken from October, 1958, to December, 1959. Sixteen of the patients were female, two were male. All patients were Negroes. The age range was from thirty-six to sixty-six, with a mean age of forty-nine years. Although several patients were taking a cardiac glycoside, none was felt to be in congestive heart failure. All but six patients had arteriolar changes on ophthalmoscopic examination of grade ii or greater (Keith-Wagner classification). In all patients, the diagnosis of benign essential hypertension of moderate severity was made.

The patients were seen in the outpatient clinic at two week intervals, and blood pressure readings were obtained with the patient in the supine position. Only those readings obtained after the patient had been lying quietly and alone for at least ten minutes were subjected to analysis. The diastolic pressure was taken as that reading at which there was complete disappearance of sounds. Resting pulse rates and weight were recorded at each visit. The medication was prepared in advance by a nurse, and was given to patients by code numbers according to a master schedule. There were four separate treatments in this study, each of twelve weeks' duration. These were (1) chlorothiazide placebo (lactose), b.i.d., and reserpine placebo (lactose), b.i.d.; (2) reserpine 0.25 mg., b.i.d., with chlorothiazide placebo, b.i.d.; (3) cholothiazide 0.5 Gm., b.i.d., with reserpine placebo, b.i.d.; (4) chlorothiazide 0.5 Gm., b.i.d., with reserpine 0.25 mg., b.i.d. The active tablets and their respective placebos were identical in color, size and shape. Each patient received each of the four treatments. Five patients started with placebos only (treatment 1); two patients started with chlorothiazide (treatment 3); five patients started with reserpine (treatment 2); and six patients were started with chlorothiazide and reserpine (treatment 4). The sequence in which the subsequent treatments were given was chosen completely at random. The twelve-week treatment periods were separated by two weeks of placebo tablets known to the physicians. Exactly two weeks' supply of medication, placed in identical envelopes, was given at each visit. At no time did the patient or the physician know the nature of the medication dispensed. The subjects were not on dietary restriction of any kind, and were not given supplemental potassium chloride.

The data obtained were subjected to analysis of variance in order to determine whether there was a

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This work was supported by grants from the Michigan Heart Association, and Ciba Pharmaceutical Products, Inc. The chlorothiazide used in this study was generously supplied by Merck, Sharp and Dohme.

significant difference between the treatment groups. When a significant difference was found at the one per cent level, the individual pairs of treatments were compared, using the "t" test. The mean values were calculated from 108 observations (six observations times eighteen patients), for each treatment group. The standard deviations and standard errors of these means are also given.

revealed a difference among the four treatment groups which was significant at the one per cent level. The mean diastolic pressure for the group while on placebo was 102 ± 1* mm. Hg.

When reserpine and placebo were administered, the mean diastolic pressure of the group was 99 ± 1* mm. Hg. This value when compared to that obtained on placebo alone was significant ($0.02 < p < 0.05$).

TABLE I. COMPARISON OF TREATMENTS—SYSTOLIC PRESSURES

Treatment	Blood Pressure mm. Mercury			Statistical Comparisons		
	Mean	Standard Deviation	Standard Error of the Mean	Placebo	Reserpine	Chlorothiazide
Placebo	178	20	2			
Reserpine	176	20	2	0.4<p<0.5		p<0.001
Chlorothiazide	159	22	2	p<0.001	p<0.001	
Chlorothiazide and reserpine	151	22	2	p<0.001	p<0.001	0.3<p<0.4

Result

Systolic Pressure (Table I).—The mean systolic blood pressure of the group while on placebo medication was 178 ± 2* mm. Hg.

The combination of reserpine and placebo resulted in a mean systolic pressure of 176 ± 2* mm. Hg. for the group. There was no significant difference between this value and that obtained on placebo ($p > 0.4$).

The mean diastolic pressure of the group when on chlorothiazide and placebo was 95 ± 1* mm. Hg. This value, when compared to placebo medication, was significant ($p < 0.001$); when compared to the diastolic pressure obtained with reserpine alone, the difference of 4 mm. Hg. was also significant ($0.01 < p < 0.02$). The combination of reserpine and chlorothiazide caused a further drop in mean diastolic pres-

TABLE II. COMPARISON OF TREATMENTS—DIASTOLIC PRESSURES

Treatment	Blood Pressure mm. Mercury			Statistical Comparisons		
	Mean	Standard Deviation	Standard Error of the Mean	Placebo	Reserpine	Chlorothiazide
Placebo	102	13	1			
Reserpine	99	11	1	0.02<p<0.05		.01<p<.02
Chlorothiazide	95	12	1	p<0.001	.01<p<.02	
Chlorothiazide and reserpine	90	12	1	p<0.001	p<0.001	.001<p<.01

When chlorothiazide and placebo were given, the mean systolic pressure was 159 ± 2* mm. Hg. The difference between this value and the mean pressure obtained on placebo was 19 mm. Hg. This represented a highly significant decrease in systolic pressure. ($p < 0.001$).

The mean systolic pressure for the group while on combination treatment of chlorothiazide plus reserpine was 151 ± 2* mm. Hg., which was 8 mm. Hg. lower than the value obtained on chlorothiazide alone. This decrease in systolic pressure with the addition of reserpine was not statistically significant ($0.3 < p < 0.4$).

Diastolic Pressure (Table II).—Analysis of variance

sure to 90 ± 1* mm. Hg. When this was compared to the value obtained for the group on placebo alone, a significant difference was found ($p < 0.001$). Furthermore, the combination of chlorothiazide and reserpine caused a drop of 5 mm. Hg. when compared to chlorothiazide alone, which was also statistically significant ($0.001 < p < 0.01$).

Pulse Rates.—The mean pulse rate on placebo was 75 ± 1* per minute; on chlorothiazide alone, it was 76 ± 1.0* per minute. On reserpine alone, the pulse rate was 67 ± 1* per minute. Reserpine caused a significant bradycardia, ($p < 0.001$), when compared to placebo. Chlorothiazide had no detectable effect on the pulse rate.

*Standard error of the mean.

*Standard error of the mean.

Weight Change.—Body weights at the beginning and end of each of the twelve week treatment periods were compared. There was found a mean weight loss of 0.5 ± 0.4* Kilo for the group while on placebo. There was a mean weight loss of 0.9 ± 0.6* Kilo for the group while on chlorothiazide alone. This weight change was not significant ($0.4 < p < 0.5$). There was a mean weight gain of 0.7 ± 0.5* Kilo for the group while on reserpine, and a mean weight gain of 1.0 ± 0.4* Kilo while on reserpine plus chlorothiazide. These weight gains when compared to treatments not containing reserpine were significant ($p < 0.001$).

When weight changes in the first two weeks of each treatment period were compared, no significant decrease attributable to chlorothiazide was detected.

Discussion

Bartells and Townley[1] reported that a significant reduction in blood pressure was obtained in 80 per cent of 65 hypertensive patients given chlorothiazide. Conway and Lauwers[3] noted that two-thirds of a group of 83 patients obtained a reduction in blood pressure on chlorothiazide alone. Freis[7] found that there was no drop in pressure in normals given chlorothiazide, and that a diet high in sodium negated the anti-hypertensive effect when chlorothiazide was given to hypertensives. Hollander and Chobanian[8] found that the hypotensive action of chlorothiazide was not impaired when dietary sodium was increased to 225 mEq. per day. Nussbaum and Hellman[12] reported that chlorothiazide alone was but weakly hypotensive in action, but that a significant reduction in blood pressure occurred with the addition of reserpine.

A well-controlled study by Darvill,[5] which assessed chlorothiazide and placebo, showed a significant decrease in blood pressure in only one of six patients given chlorothiazide alone. In another group who were given reserpine or hydralazine in addition to chlorothiazide, a statistically significant reduction in blood pressure occurred in six of fifteen patients.

In the present study, a distinctly significant anti-hypertensive action has been shown for chlorothiazide. A further significant drop in the diastolic pressure occurred with the addition of reserpine.

The mechanism of action of chlorothiazide as an anti-hypertensive agent still remains obscure. Many workers have noted a decrease in plasma volume and total body weight, coincident with the naturesis induced by chlorothiazide administration. Dustan[11] believes that the hypotensive action is related to oligemia and decreased cardiac output which occurs with continued chlorothiazide administration. The oligemia is associated with an increased total peripheral resistance, which probably represents increased vasomotor tone. Such an increase would explain the enhanced effect of ganglioplegic drugs in patients who are receiving chlorothiazide. The hypotensive effect of chlorothiazide can be abolished by infusion of sufficient dextran to revert plasma volume and cardiac output to pre-treatment levels.[6]

Oligemia is apparently not a factor in the continued hypotensive effect of chlorothiazide, though it may be important initially. In the present study, there was no significant decrease in body weight after either two or twelve weeks of chlorothiazide treatment. Vertes and Sopher[16] noted that though an initial weight loss occurred, the weight reverted after a few days to pre-treatment levels. The serum sodium and chloride concentrations returned to normal after an initial fall. Conway and Lauwers[3] found that on long term therapy (mean of 77 days), the cardiac output and plasma volume returned to normal after an initial reduction in both parameters. They also found that there was, in fact, a slight decrease in the calculated total peripheral resistance on long term chlorothiazide administration. As they point out, reversing the increased peripheral resistance characteristic of essential hypertension is a physiologically satisfactory method of treatment.

The weight gain noted in our patients with reserpine administration was noted to be statistically significant, and was probably related to increased appetite. A similar significant weight gain with reserpine was noted in a previous study, which evaluated reserpine, syrosingopine, phenobarbital and placebo by the double-blind technique.[15]

In the present study, there was no demonstrable change in pulse rate attributable to chlorothiazide. As would be expected, a significant bradycardia was noted with reserpine administration. Chlorothiazide did not significantly alter the bradycardia caused by reserpine. Skin lesions, purpura, postural syncope and weakness were not encountered in this study. In conclusion, utilizing the double-blind technique, a significant anti-hypertensive action of chlorothiazide, when used alone, was demonstrated. A further reduction in blood pressure occurred with concomitant administration of reserpine.

Summary

Using the double-blind technique, the effects on the blood pressure of chlorothiazide, reserpine, chlorothiazide plus reserpine, and placebo were assessed. Each of the eighteen hypertensive patients studied received

*Standard error of the mean.

each of the four treatment regimens. The dosage of reserpine was 0.25 mg. twice a day; and that of chlorothiazide, 0.5 Gm. twice a day. The mean systolic pressures were: placebo, 178 ± 20 (standard deviation) mm. Hg.; reserpine, 176 ± 20 mm. Hg.; chlorothiazide, 159 ± 22 mm. Hg.; and chlorothiazide plus reserpine, 151 ± 22 mm. Hg. The differences between placebo on one hand and either chlorothiazide or chlorothiazide plus reserpine on the other were significant ($p < 0.001$). Reserpine alone did not significantly depress the systolic pressure, and its addition to a regimen of chlorothiazide did not further significantly lower the systolic pressure. The mean diastolic pressures were: placebo, 102 ± 13 mm. Hg.; reserpine 99 ± 11 mm. Hg.; chlorothiazide, 95 ± 12 mm. Hg.; and chlorothiazide plus reserpine, 90 ± 12 mm. Hg. All of these means were significantly ($p < 0.05$) different from each other. No significant change in weight or pulse rate was caused by chlorothiazide. Reserpine caused a significant bradycardia and weight gain.

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Diabetic Diathesis

If you're going to get diabetes in middle age, the disease is developing right now. Dr. Jerome W. Conn, of The University of Michigan Medical Center, reported his views to the Pan American Congress of Endocrinology meeting in Lima, Peru. Dr. Conn said every victim of diabetes is born with the disorder. He urged medical scientists to find new ways to identify the disease in its earliest stages.

One clue, he said, shows up in the "high incidence of fetal complications of pregnancy in women who are destined to become diabetics many years later." But there are other traits and signposts not yet understood by medicine.

The classic symptom of diabetes is the breakdown in carbohydrate metabolism: when the body can no longer manufacture enough insulin. But, says Dr. Conn, "This represents a very late stage of the diabetic syndrome. Ultimately, we want to divide the symptoms of diabeties into those which predate and those which follow the onset of this hypoinsulinism.

"The prediabetic state is not the lull before the storm," Dr. Conn said. "It is a dynamic period in the evolution of clinical diabetes."

Regional Perfusion of Malignant Lesions

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NO ONE knows better than the surgeon that the ultimate answer to the problem of neoplastic disease does not lie in more extended operative approach. The frequently systemic or at least regional nature of the common malignancies makes one realize that the ideal treatment for most of these patients will come one day in some form of cancerocidal drug. A drug which can so alter the metabolic activity of the neoplastic cell that it cannot continue a rapid rate of mitosis. Such drugs are currently available. They all, however, have sufficient toxicity to normal cells and organs to preclude their systemic use in strictly cancerocidal doses. In the last fifteen years, some 50,000 drugs have been evaluated in various laboratory situations for chemotherapeutic effect on tumors. It is interesting to observe that one of the earliest agents known, nitrogen mustard, is still considered by many to be most useful in most cases.

In recent years, several groups in the United States, led by Dr. Oscar Creech in 1957, have described isolation perfusions techniques for increasing the dose of cancerocidal agents to the regions involved with tumor. With current methods, the concentrations of cytotoxic agents delivered to the tumor can be increased six to ten times over that possible by systemically administered drugs. An equally attractive feature of this method is the ability of the surgeon to largely exclude the cancerocidal agent from the systemic circulation. In this way, the common complications of chemotherapy, such as bone marrow depression and gastrointestinal upsets can be largely eliminated.

Nitrogen mustard has been used more in chemotherapy than any other drug. It is an alkylating agent whose effects are manifest as a nucleotoxic reaction. 5-Fluorouracil is a pyrimadine analog which is fundamentally an antimetabolite. It seems to hold most promise in the treatment of adenocarcinoma which is generally resistant to chemotherapeutic agents. Phenylalanine mustard was first synthesized by Larinov in Moscow as Sarcolysine. It is similar to nitrogen mustard but more toxic particularly to bone marrow. Triethylene-phospho-amide is chemically related to nitrogen mustard and is similarly a nucleotoxin.

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Techniques

All of the isolated perfusions techniques have several features in common. The tumor bearing area must be located in such a region that fairly complete isolation of the arterial and venous supply is anatomically feasible. The extremities and lungs fulfill this criterion most completely. Other areas, such as pelvis, breast and head, are less desirable but have been perfused on many occasions. The necessary equipment for all perfusions except lung includes a Sigmamotor pump, a disposable bubble type oxygenator, an oxygen supply and the necessary lines and cannulae to connect the patient to the apparatus (Fig. 1).

The pump oxygenator is primed with five units of heparinized blood and oxygen is passed through the blood oxygenator. There is abundant experimental evidence to demonstrate that the available chemotherapeutic agents have a higher index of activity in blood with a high oxygen tension. Also, the normal tissue in the area is not allowed to become anoxic during the thirty to forty minutes the perfusions require. The arterial and venous supply is occluded proximally and the cannulae are then inserted below the clamps in the major artery and vein to the area.

The usual flow rates vary from 100 cc/min. in an upper extremity to 800-900 cc/min. in the lungs. If these set levels are significantly exceeded, capillary rupture from increased pressure causes complications in the post perfusion period of edema, pain and skin vesiculations. A tourniquet of the Esmarch variety is ordinarily used to minimize systemic leak from the extremity perfusion circuit.

The chemotherapeutic agent is injected into the per-

fusion circuit between the oxygenator and the arterial pump. This minimizes streaming and unequal distribution. The usual technique is to administer the total dose in four divided doses with an interval of perfusions between doses sufficient to allow for the maximum activity of the drug in the tissues. With the two agents we have commonly used this is five to eight minutes. We have elected to use nitrogen mustard and 5-Fluorouracil in the early cases presented to us for perfusion for two reasons. First, there is no clear evidence that any other agents are superior.

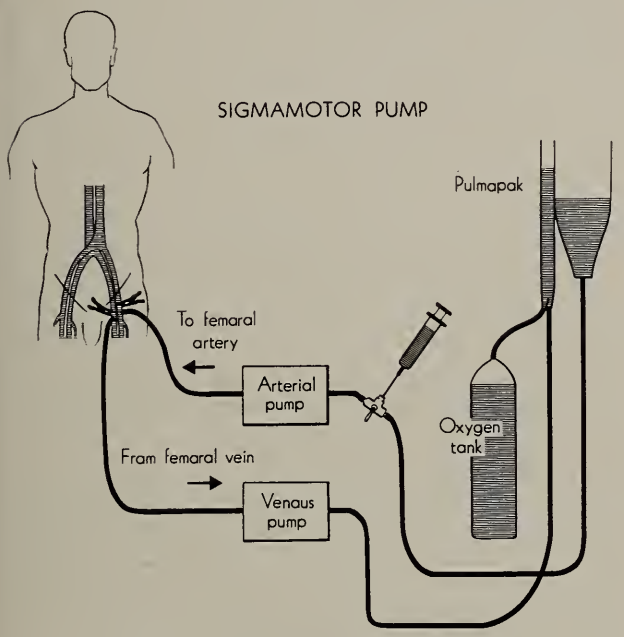


Fig. 1. Typical perfusion technique.

Secondly, the period of activity of these two cytotoxins is short so that at the end of the procedure it is not necessary to wash out the area perfused and reinfuse blood and/or blood substitute. In those drugs with a long period of tissue toxicity, this washing out, of course, is necessary so that these agents are not allowed to re-enter the systemic circulation in toxic amounts when the perfusion is completed.

One of the hazards in this procedure is that the vascular isolations of the area to be perfused is not complete and that a prohibitive leak of the cytotoxic agent will occur. Several methods have been devised to test the completeness of isolation. In the early cases, we injected Evans blue dye into the perfusion circuit and after allowing this circuit to run for five minutes, drew a systemic blood sample from the anticubital vein. Serum is examined photoelectrically and any serious leak can be detected. More recently, the use of serum albumin tagged with radioactive iodine has become available to us. This determination is done in the same manner as is done with Evans blue except the per cent of leak is estimated with a well scintillation counter using again systemic blood

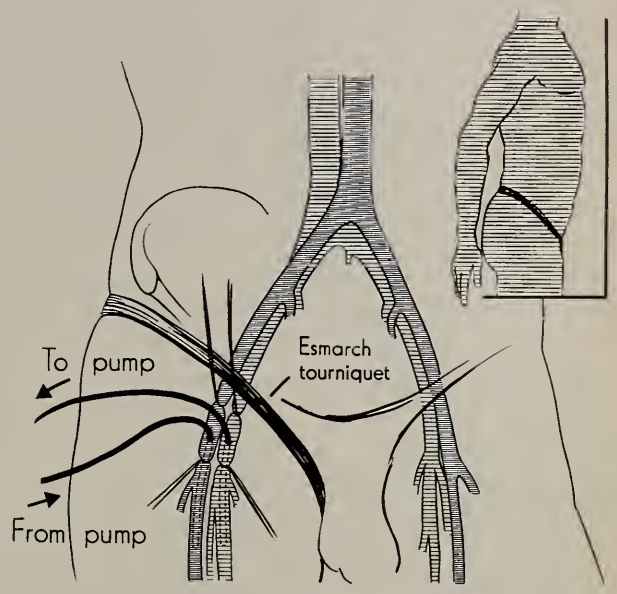


Fig. 2. Lower extremity perfusion.

sample. In general, leaks from the extremities and lungs have not been troublesome, however, those from the pelvis have run as high as 25 to 30 per cent on occasion.

Regional Techniques

The lower extremity lends itself better than any other locality to isolated perfusions. The common femoral vein and artery are isolated and cannulated. An Esmarch bandage is applied above. All of our leg perfusions have been done for melanoma (Fig. 2).

In the upper extremity, the brachial vein and artery are cannulated in a similar manner. The tourniquet is applied. The arm perfusions have been for sarcoma.

As mentioned earlier, the pelvis is a far from ideal location. Systemic leak has been sufficient to cause thrombocytopenia in two cases. The common femoral vessels are exposed bilaterally. They are cannulated and connected to the pump on one side and are occluded with clamps on the contralateral side. The aorta and inferior vena cava are exposed through an abdominal incision and both are occluded. The perfusion is then started, and the system is tested for leaks. This technique has found most use in patients with postoperative abdominoperineal resection who have perineal or presacral recurrence (Fig. 3).

The technique used for the lung differs from other

perfusions in that the systemic circulation must be maintained during the perfusion with a second pump oxygenator of the Kay-Cross variety. The pulmonary circulation is replaced by the blood containing the

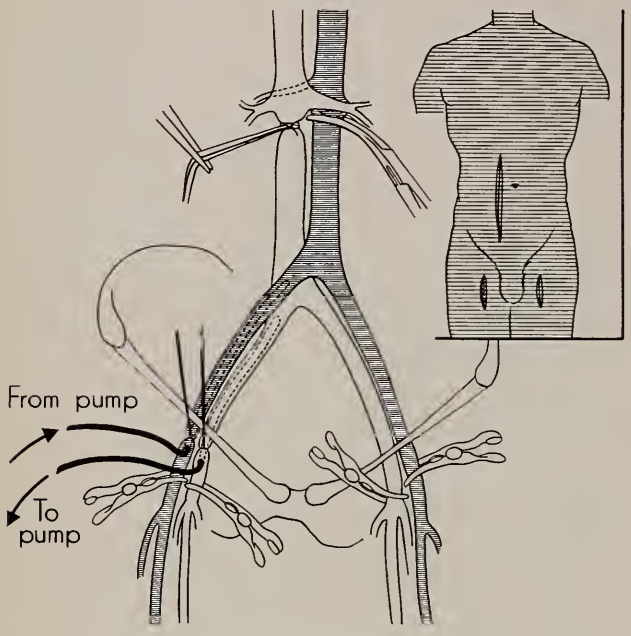


Fig. 3. Pelvic perfusion.

cytotoxic agent. This is accomplished by cannulating the femoral artery for systemic arterial inflow and the right atrium for venous outflow. The pulmonary circuit is then perfused by cannulating the main pulmonary artery for inflow and the left atrium for pulmonary venous return to the Sigmamotor pump.

TABLE I. COMPLICATIONS

Death	2
Edema of Extremity	6
Hematopoietic	2
Gastrointestinal	2
Slough of Skin Flaps	1
Wound Infection	1

Complications (Table I)

Two of our patients have died as a result of the procedure. One, we have every reason to believe, died of an overdose of curare. The anesthetic record and the clinical course postoperatively support this conclusion. The other death was due to hemorrhage twenty-four hours postoperatively from a major vessel which was poorly managed.

The commonest complication has been edema of the extremity. This has presented no great problem, responding in each instance in three to four days with conservative measures such as compression bandages and elevation.

Hematopoietic difficulties of minor degree have been seen in several patients each a pelvic perfusion. Thrombocytopenia and anemia were the usual abnormalities noted. In each instance this responded to not more than 1000 cc. fresh whole blood and did not recur.

Nausea and occasional vomiting have also been seen but were of no great magnitude.

Types of Tumors Treated

We have perfused five melanomas, five carcinomas and two sarcomas.

It should be mentioned that in no case did a patient have perfusion as a solitary procedure. The usually accepted modalities of treatment such as wide local excision, radical node dissection, resection and x-radiation were used with perfusion as an adjunctive measure.

TABLE II. RESULTS

One to Nine Months Post-perfusion

Alive Without Evidence of Disease	7
Alive With Evidence of Disease	3
Dead	2

Results—One to Nine Months Post-perfusion (Table II)

With the exceptions of the two operative deaths, all the patients are alive at this time from one to nine months post-perfusion. There are seven alive without clinical evidence of disease now and three alive with residual or recurrent disease.

At this time, no one would recommend region perfusion as a sole mode of treatment in a case where the standard surgical procedures have been shown to cure or to palliate effectively. For that reason, few patients, none in our series, can be critically evaluated at this time as to the precise effect the chemotherapeutic agents alone have had in the course of their disease. There are certain instances in selected cases, however, where the method seems to have applications as being theoretically and practically superior to operative treatment.

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The Challenge to the Professions

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IN HIS *Landmarks of Tomorrow,* Peter Drucker, famed Columbia University professor of government, suggests that we have entered the post-modern world. He explains that our period of history is a transition to a time in which mankind will possess the knowledge and skill, about himself and about things, to control the nature and the rate of change. He further concludes that among the characteristics of this transitional epoch is a healthy skepticism and reorganization of scientific knowledge, and that no discipline or profession is immune from the process.

When one places this thought against our day of science, technology, and the professions, the layman is in jeopardy when he addresses himself to the enormous edifice which we call the professions. It is more and more true that the organization of knowledge is possessed by the specialists. We run the increasing risk of little knowledge overflowing into the common awareness of the layman. So I am convinced that a critical question of our time is the choice between where science and technology, and the professions which practice them, will take us or where we shall take science and technology. A central challenge to the professions in the post-modern world is that we must explore the nature of the aims to which scientific and technological consequences shall be directed. The values and the ethical codes of man, not science, respond to the question of human ends. So I take this challenge to the professions as my topic today, with the mood of a person who knows how little he knows, but recognizes there can be no "man-thinking," in Emerson's terms, unless he is willing to view the significance of science and profession to the human condition.

The professions, I must contend, are of paramount importance to the future of the world. I can say this without qualification, because they not only possess the world's knowledge; they organize it and ethically govern its application in the social welfare. In the increasing world-wide society, change is taking place at remarkable and, in some ways, dangerous rates. As Sir Charles Snow, the English novelist, puts it: "The ingredient that we are also remarkably and dangerously short of is foresight." Every man who is a professional in the truest sense realizes that he knows more than did his predecessors, and he also realizes that he will be out-dated by his sons if they choose his profession. So we must reckon that the true professional will have a kind of built-in humility about change; that while the future grows out of the present, it always turns out to be different. In our kind of world this kind of man can be trusted. If he cannot be, where, in a world which thrives and suffers on the basis of the presence or lack of knowledge, will human or social wisdom come from? To possess and nuture wisdom and foresight is today's and tomorrow's awesome responsibilities of the professions.

Your attention is called — in passing — to the growth of the professions relative to the total population. As one example, there were 250 certified public accountants in the United States in 1900; today, there are more than 50,000, and it is calculated the figure will probably double by 1970. Professional personnel constituted 1.9 per cent of the working force in 1850, 3.8 per cent in 1900, and 6.4 per cent in 1950. From 1850 to 1950, the working force increased about 7.7 times, and a typical profession increased anywhere from 25 to 300 times. Within the last five years, "professional, technical, and managerial" people had become the largest single group in the working population in the United States.

The Author

PAUL A. MILLER, Ph.D.



Address delivered to the Delegates of the 2nd Annual Congress of the Professions, February 23, 1961.

Dr. Miller, new president of the University of West Virginia, was provost of the Michigan State University, when he presented this address.

As the numbers grow, organizations of the professions become increasingly self-conscious, beyond the superficial sense of using a special professional jargon which shows that one is a member of some kind of inner ring or inner circle. Some of the self-consciousness seems to be based upon economic and legal self-defense. In his *Acquisitive Society* (page 92), Tawney seems to define a profession simply as a trade which is organized for the performance of a function. Some critics within the past twenty years have suggested that professions risk being predatory conspiracies against society and that professional autonomy may become a license from the public which grants the opportunity to exploit the public. But I am confident that today's professional leaders realize that self-regulation and ability to include or exclude members on a professional basis does entail monopoly privileges.

COMPLICATIONS

But certain complications get in the way of a full assumption of this responsibility. May I cite them, not to appear fatuous, but simply to yield one man's view on those complexities from which the professions are as yet unable to be free.

The first complexity is that the fences between the compartments of traditionally organized knowledge keep falling down. Although we frequently persist in preserving scientific disciplines along often outdated lines of organization, the nature (both physical and biological) forces us to consider ideas and concepts which no longer respect tradition. For example, the literature of the profession of medicine indicates that the biological perspective is the background of all medical problems; that biology is no longer the mechanical addition of botany and zoology; that it is only now, with the merger of biology with chemistry and physics, that we are viewing new breakthroughs in biology as an exact science. The recent developments in cellular chemistry and genetics, in reducing problems as consequences of chemical and physical phenomena which are generated in the living organism in relation to environment and inheritance, calls into question the adequacy of much of our disciplinary organization of theory and practice. Accordingly, with medicine still the example, even the traditional lines between human medicine and animal medicine are being erased—as was predicted by Rudolf Virchow seventy-five years ago, more recently by Sir Henry Tizzard, and by such early famed physicians and surgeons as John Hunter, Sir Jonathan Hutchinson, and Sir William Osler. In short, the newer adventures in the professions are rapidly beginning to deal with the improved sense we have of the connection of things.

The second complexity which may blur professional vigor is that most of us take for granted that the professions have been with us always and that their status, powers, and functions will remain essentially the same in the future. But nothing about professionals or professional life can possibly remain static. Most assuredly, the demographic facts and the burgeoning of knowledge, coupled with the increasing self-consciousness of larger and larger portions of more and more populations in under-developed areas—and this self-consciousness pressing first for human equity —means that professions have a fascinating time ahead of them—particularly if human equity around the world is one of their major goals.

The history of the professions suggests a continuously dynamic and restless development. In spite of some contrary opinion, no profession was endowed full blown by the Creator; all the professions have emerged from arts and crafts or occupations bearing upon necessary public interests and needs. In many areas of service we find that an occupation is an "incipient profession" striving on for socially responsible and educated practice. It may cause us to smile when we consider that midwives have a high professional standing, with most of the typical attributes of a profession, in many foreign countries (including some even on the European Continent). Yet we must recall that when medicine was a full-blown profession, surgery was considered as a sideline for barbers. The surgeon was not included among those who called themselves professionals.

As it turned out, the "standard" professions of law, medicine, and theology first added the armed forces by the 16th Century and were all gentlemen's professions. Within the last 150 years there has been added dentistry, veterinary medicine, pharmacy, engineering, architecture, and public accounting, to name the chief among them. Those who are in incipient professions (or in professions which are not recognized by the older ones) may complain here, but it might be granted that if the whole society does not recognize professional status, possibly something is wrong with the way the profession has defined and transmitted its ideals. Incidentally, a most cursory observation leads one to say that hardly anyone is more insecure, or more insistent upon professionalism, than members of incipient or changing professions. Social work is perhaps the best example of this phenomenon. In any event, one can clearly see in their history that the articles of incorporation of professional organizations

show that the first step in professionalization is to elevate the profession as such.

A third complexity is the requirement of never-ending attention to the profession's meaning. It is not always clear that professions have been interested in careful definition of the nature of a profession. (1) Typically, one could say that a profession is a unique, definite, and essential social service. If it fails in this, the service or profession cannot agree on issues of educational preparation, ethics, and compensation. (2) A second characteristic is emphasis upon intellectual techniques in performing the services, including knowledge of a discipline, the ability to define problems in the search for data, and formulating a *range* of solutions. A corollary of this characteristic is that a long period of specialized training is probably necessary. (3) In spite of the specialized training, we assume in a profession a broad range of autonomy for both the individual practitioner and for the occupational group as a whole. Training is not enough. The professional as such must exercise independence and judgment. The responsibility for his own performance is a key point, especially when one considers the influence on human welfare of the typical professions. (4) An underlying aspect of a profession is the emphasis upon service to be rendered rather than the economic gain. This does not mean that some people do not enter a profession chiefly to earn a living. The point is that the professions are so organized and controlled that the members therein have certain obligations which cannot be avoided regardless of their personal feelings. If the profession is self-governing, it sets its own standards for entry and exclusion as well as its own standard of practice. (5) A profession has a code of ethics which has been clarified and interpreted at ambiguous and doubtful points by concrete cases.

Note that some of the salient characteristics of a profession fall in the areas of Service, Responsibility, Duty and Judgment. A profession is a high calling, indeed, and we do not call those served customers but rather "clients," and the clients are not in a position to judge the quality of the service for themselves. "Let the buyer beware" does not apply to professional services. We seem also to assume in some cases that the professional person stands even beyond the client. Is it not interesting that one of the functions of a public accountant is often to assure two strange parties that they are telling the truth to one another. A survey of physicians in Philadelphia in 1953 showed that a majority did not tell the patient when he had cancer, although they always told some member of the family.

Another interesting characteristic is that the motives and the conduct of the professional are of equal if not greater importance than his sheer ability. More than one professional code indicates that his function is not "business"; most professional codes refuse the possibility of advertising. These two key characteristics pose interesting problems for those who hope to make business administration a profession and those who consider advertising a profession.

A fourth complexity for professions in modern society is the nature of their relationship to other professions and to the community. Many years ago a British observer referred to, "The undisguished contempt in which both solicitors and barristers . . . hold and have always held not only all scholarship or academic learning of the professional kind, but also any theoretic or philosophic or scientific treatment of the law." This is an old criticism, but it is always possible when a profession defines the relationship as an attitude of one professional to another within the field and forgets the relationship of the profession to the whole community. Typically, the codes of lawyers do not contain criticism for ignoring problems relating to the limitation of litigation, and the medical codes do not question the doctor for ignoring preventative medicine. Criticisms of this sort have gone back as far as Theophrastus and Chaucer, but they are expressed today as well. It is worth noting that the independence of the professions was believed to be such a serious matter in the middle third of the 19th Century in America that the professions were everywhere reduced in their privileges and weakened considerably. The professions of law and medicine, in particular, have only begun to recover from this 19th Century experience during the past 50 years or less. If a profession in tomorrow's world does not engage in continuous self-examination, research, and self-criticism, it may encounter increasingly complex problems and expect encroachment on the part of the public officials or by "pseudo" professions. A related challenge is that the professions may profitably encourage professionalism in other areas, rather than denying the possibility of professionalism outside their own. The two that I have in mind at the moment are school teaching and civil service. The necessary service to society, the ethical codes, the education, the aspects of altruism are all there, but it has occasionally seemed that existing professions half-heartedly assist both teaching and the civil service into emerging as genuine professions. This is one important reason why I commend such an organization as this.

A fifth complexity in the post-modern world is the splintering of functions and attitudes within the pro-

fessions. We Americans have possessed the genius to create bigness; we must now find the genius to manage it. For instance, Michigan State University currently receives 336 medical periodicals, and this is exclusive of periodicals in the pure sciences. A random survey would indicate that the average number of years of publication of these periodicals is about twenty, giving evidence of the increased specialization within medicine. There was only one specialty medical board in 1917, and today there are twenty. Specialization, new techniques, group practices, and new technical materials and practices have caused genuine ethical problems within the profession, without raising the questions of the ethics of radical therapies, from prefrontal lobotomy to euthanasia. How does one maintain a single profession under these circumstances?

Another example of fractionation is found in engineering, where the journals, if anything, outnumber those in medicine, and there is not too much communication among the engineers in various fields.

The fifth complexity is the hard one: the ethical and philosophical outlooks of the profession. For example, I believe you will grant the problem when we see that almost every profesional code insists that no service be given without a fee, yet at the same time the professional code insists that the service the professional has to give is essential for the good of society and the individuals within it. Another example today is that the professions become increasingly more technical and specialized and the fundamental sciences and the arts which underlie them are assumed somehow or other to be in the background of the professional. Increasingly, lawyers are suggesting that a course in "professional ethics" be included in law school. If such a course is needed as an afterthought, one can suspect that the special and technical courses in the law are either misconceived or poorly taught. One might conclude that the professional education of separate practitioners might have more fundamental approaches to the science and arts in order that they could cope in the future with the changes facing them.

The sixth complexity relates to both the power and the influence of the expert and his expertise. Most professionals have learned to insist upon accuracy within their profession and have pursued some kind of precision defined by their function. This may give both the professional and the public a false sense of accuracy and security when the professional moves outside the realm of his specialized work. Occasionally, the respect and confidence the professional commands in his own work can confuse him in other fields. Technical proficiency, specialized knowledge, obtuse vocabularies are not necessarily things which result in our to be hoped for social wisdom and foresight. Indeed, professional routine, along with the demand for accuracy and precision, may lead to a lack of flexibility once the professional approaches the margins of his special subject. Indeed, such knowledge can sacrifice even the common sense derived from daily experience by many nonprofessionals.

Yet, if some of the key characteristics of professionalism are embodied in the words Duty, Responsibility, Altruism, it may follow that the changes affecting the professions in terms of new techniques, new scientific discoveries, and splintering and specialization will lead the professional to seek less power, more education, and the ultimate result might be a still more humane influence. If this were the case, then the professional will willingly re-examine his position, keep on hoping to enlarge his service and significance, and then, having learned something about himself, would be seeking to be of ever more value to society.

MORAL COMMITMENT

The foregoing remarks were intended to illuminate the fact that at the core of a profession is a moral commitment. This is so because its task is the application of truths, together with human perspective and judgment, to the needs of society. There is no need to elaborate before this audience about the significance of truth, perspective, and judgment in today's world. I am interested in these qualities, not only because they are the major strategic items for modern problem-solving, but also because they form the wellspring of humility, which is also an urgent necessity in a world community confronted with rapid and dangerous change. Since most professions apply scientific truths, they are therefore in the position of "moral unneutrality," as Father Hesburgh of Notre Dame has recently expressed it. This is a terrifying responsibility if the quality of humility is absent from it.

The professional person will and must recognize that the truths he applies are not all completely certain. He joins with the scientist in this recognition, but his task is in some ways more difficult in that his applications are always being fitted to varying sets of extenuating circumstances. I quote a phrase from Dr. Richard Feyman in a lecture on science in 1955. "We have found it of paramount importance that in order to progress we must recognize the ignorance and leave room for doubt. Scientific knowledge is a body of statements of varying degrees of certainty—some most unsure, some nearly sure, none absolutely certain. . . . Now we scientists are used to this, and we take

it for granted that it is perfectly consistent to be unsure—that it is possible to live and not know." This is one humility-inducing root of both science and the professions.

The second humility-inducing root of the professions is that by their very nature they recognize that not everything can be reconciled. The true professional will admit of the enigmas of the universe and will not attempt through easy rationalization and compromise to explain them away. Instead, he will realize that it is precisely these enigmas which give him and all people an excitement in life and that to explain them away is antithetical to freedom. George Orwell in his gloomy book, 1984, reveals how freedom is associated with conflict, not with the use of knowledge, by those who possess it, to reconcile and rationalize all the issues and enigmas for those who do not.

The third root of humility for the professional man is that it is precisely the knowledge that he possesses, and the diciplines by which he uses it, which are involved in the current world struggle of social revolution. As professional organziations in America, what, then, are we going to do about it? It would be easy for us to face inward to ourselves and, perhaps without too much difficulty, increase our own luxuries. But sanity in this world is tied up with reducing the gulf as quickly as possible between people like ourselves and the multitudes which live midst the dying wails of their children, stomachs eroded with hunger, squalor, disease, and the awareness, which cannot now be blunted, that it doesn't have to be that way. At the bottom of it is knowledge and the ability to apply it.

Thus, the world is searching for a new idea to replace the one which encircled the earth for hundreds of years and is now dead or dying. That idea was colonialism. With all of our organizational and disciplinary wisdom in the professions of America, what can we do to help the search? Next, I am sure that the professions stand as guardians of our pride in the freedom and flexibility of our *domestic* institutions and in the preciousness of our *political* institutions. But how may we add to this pride the compassion for those who stand on their own land beside the graves of their fathers and fear us. What is to be our great proclamation of hope to the world, when it is the lack of the very knowledge which we possess that feeds the fear of those in the hut and the peasant's cottage. And, finally, how may we join hands with professional men wherever they are, realizing that the creeds of a profession rise above all classes of men, all colors, all systems of status, all languages. This is the great outward-facing responsibility of the professions in America today. I believe that it is critical that we find great words to be followed with great deeds. I believe that we have the words; I am not so sure about the deeds. How we respond with deeds will determine how future historians, if there are any, will treat this critical hour of U. S. history.

Childhood Poisonings

Poisoning is the most common and most serious pediatric medical emergency—toddlers and young children under five years of age are the chief victims.

William M. Browning, M.D., of Indianapolis advises: "If a poison is taken by mouth, remove the unabsorbed poison. This may be done by emetic, lavage or removal of source. Identify the poison. If labeled, call the poison control center to identify the ingredients. Administer an antidote. Give antagonist when available." Although the "universal antidote is neither universal nor antidote," it is excellent when no specific antidote is available. The formula includes: pulverized charcoal—burned toast—2 parts; magnesium oxide—milk of magnesia—1 part; tannic acid—strong tea—1 part. *Journal of the Indiana State Medical Association*, August, 1961.

Maintenance of Function in Lesions of the Nervous System

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THE RELATIONSHIP between neural structure and function has always been a fundamental issue in neurology. In the past, it has been assumed that such a correlation is fixed and direct and that, therefore, anatomic changes should be associated with simple and predictable alterations of function. Conversely the notion became accepted that, given an abnormal function as the known factor, one should then be able to predict the changes of the anatomic substrate. This concept, which embodies the theory of localization, led to impressive advances in the past, yet it failed to explain many vagaries of the neurologic symptomatology. Even now, the classic theory of localization has some faithful adherents who, armed with brain maps, continue to assign specific function to sharply delineated areas. One cannot help wondering whether such an approach is not a survival of Gall's pseudoscientific concept of phrenology.

Before analyzing the relationship of structure and function, we must briefly digress and inquire whether our present methods of investigation are trustworthy. To begin with anatomy, everybody will agree that macroscopic inspection alone is unreliable. It should be remembered that many conclusions of the older literature were supported only by gross anatomic findings and were not sufficiently checked by later observers. Histologic examination, no doubt, is a methodologic refinement, especially the newer techniques of silver impregnation, histochemistry, phase and electron microscopy; but let us not forget that even these methods do not show all existing structures and offer only equivalent pictures of artefacts which resemble live cells no more than a stuffed museum animal resembles a wild one. Study of tissue cultures, such as Pomerat's work, therefore, may reveal the behavior of living cells more realistically. Turning to the methods of functional exploration, we still rely much on the clinical examination which is a crude version of physiologic tests. Repeated examination adds the dimension of time, and often, a characteristic temporal profile helps the clinical diagnosis. Modern physiologic methods, such as the investigation of electric activity and biochemical behavior of the nervous system, have greatly advanced our knowledge. Yet, it seems doubtful whether all the complexities of the life process can ever be fully encompassed by means of mere physico-chemical quantitation. On the other side of the ledger, psychologic concepts, such as the theory of conditional responses, the psychoanalytic approach in psychosomatic disorders, and the application of the Gestalt theory, have supplemented and sometimes opposed the ideas of the organicists. To sum it up, we now possess many different and refined methods, but realizing their limitations, we must use them critically, i.e., regard them only as sources of approximative information.

Our next problem is posed by the question, "Which are the anatomic and physiologic mechanisms that maintain function in the intact nervous system?" Speaking in teleologic terms, we may answer: "The more vital a function is, the better it is safeguarded." Many anatomic and physiologic devices provide for multiple and supplementary innervation, diffusion of impulses or storage of previously evoked patterns of excitation. The morphologic substrate for a vital function is usually found to be laid down in multiple, often spatially separated pathways. (For example, the neurologic control of respiration and of the wakeful state.) Thus, with the main pathway destroyed, an auxiliary system will maintain function. On the other hand, highly specialized, but not vital motor or sensory performances, are carried out by discreet, somatotopically arranged structures. This is true for certain specialized cortical areas, such as so-called motor, sensory and visual spheres, and also for some of the common terminal pathways.

Let us now review some of the *anatomic* provisions which safeguard the continuity of function: In the brachial and lumbar plexuses, for example, the mingling of nerve fibers of various segmental origin is obvious even to gross inspection and also within the peripheral nerve trunks the fibers are arranged in a

plexiform manner rather than in distinct cables. Proper maintenance of motor and sensory functions is guaranteed by a multisegmental innervation of the muscles and skin. There is an overlap of at least three sensory dermatomes at the level of the trunk and this overlap amounts to more than six segments as far as the sympathetic preganglionic innervation is concerned. Within the central nervous system, the integrity and continuity of function is protected by multisynaptic short neuron chains such as the internuncial neurons, intersegmental connections and the vast carpet of the reticular system, all of which serve to diffuse impulses. Another morphologic device is bilateral representation by means of crossed and uncrossed tracts and commissural systems. A good example for the ability of the intact nervous system to maintain function under stressful circumstances is given by the situation in intractable pain, assuming we consider pain as a process of excitation and, therefore, a positive function. When, for instance, a major pain pathway has been interrupted by cordotomy, the pain impulses may still break through and thus find their way to the level of consciousness by devious auxiliary routes, such as short, multisynaptic connections up to the reticular substance. It is as though in a flood, after the main break in the dam has been sealed, the water finds its way around the obstacle by flowing through nooks and crannies.

This brings us to the central theme of our discussion— the maintenance of function in the presence of a lesion. The proponents of the localization theory believed that a focal defect resulted in a subtractive loss of exactly that function which was supposedly exerted by the damaged part. We believe now that the performance of the injured nervous system is changed and usually reduced, but a new pattern of function emerges—namely, that of the integrated responses of those parts which have remained intact. If a lesion happens to destroy highly specialized structures or important common terminal paths, a serious and conspicuous local deficit will ensue. Paralysis after destruction of the pyramidal tracts and homonymous hemianopsia in an occipital lobe lesion are illustrations of this phenomenon. If, however, the lesion affects less crucial structures, there will be only a more or less marked quantitative or qualitative reduction of function which may manifest itself in a dedifferentiated and disorganized performance. Disturbances of function result not only from anatomic defects, but occur also in conditions in which the nervous system is constantly bombarded by abnormal physiologic impulses from an irritative focus. This is the situation in certain cases of focal convulsive disorder. Elimination of the trouble-making focus by lobectomy or hemispherectomy will restore the harmonious function of the remaining parts.

Three main factors determine the way function is maintained in a damaged nervous system: (1) the time element, (2) location and size of the lesion, and (3) the specific nature of the pathologic process.

Time Factor.—It is well known that, given two lesions of identical location and size, the acute one will produce a far greater functional deficit than the slowly developing chronic lesion. V. Monakow called this global disruption of function following sudden catastrophic insult "diaschisis." The usual explanation for the phenomenon is that complete, but temporary breakdown of integration is caused by abrupt cessation of impulses playing upon physiologically collaborating but anatomically uninvolved pathways. On the other hand, the nervous system can adapt itself with a minimal loss of function to very slowly progressive or longstanding lesions. This is exemplified by certain developmental and congenital conditions. Some patients with advanced hydrocephalus show unimpaired higher cerebral function despite an extremely thin hemispheral pallium. Patients with cervicodorsal hydromyelia in whom the spinal cord is transformed into a thin-walled tube may exhibit amazingly little loss of motor and sensory functions. If, however, the precarious balance of such a compensated situation is disturbed, for example, by an operation, a catastrophic breakdown of function may occur.

Site and Size of the Lesion.—The degree and type of functional deficit obviously depend on location and size of a lesion. If a densely concentrated pathway endowed with special function is destroyed, impairment of performance is likely to be severe, or at least more readily recognizable than when a diffuse neuronal system is affected; yet, it is surprising to note that sometimes a considerable portion of a compact pathway can be destroyed without discoverable loss of function. For example, partial section of a trigeminal root at the pons may not result in tangible sensory loss.

Nature of the Pathologic Process.—It is challenging to compare the effect of the various pathologic processes on neural function. In the past, the effect on

the neural elements *per se* had been unjustifiably overemphasized by neurologists, whereas other associated effects had been somewhat neglected. In reality, most pathologic conditions are not limited to neuronal damage but often produce also changes in the blood vessels, blood circulation, production, circulation and resorption of cerebrospinal fluid and intracranial pressure, et cetera. Furthermore, it is important to know whether the disease process is stationary, progressive or regressive.

Let us now consider these ideas in some concrete situations:

1. Amyotrophic lateral sclerosis is an example of a degenerative lesion of the motor system, that is, a condition in which the criterion of an almost pure neuronal lesion is fulfilled. No substituting mechanisms are available to compensate for the deficit because important terminal pathways are involved. Consequently, one finds here a close and accurate correlation between anatomic damage and functional loss.

2. Next, we wish to analyze a case of a complete traumatic transection of the cord. After the initial diaschisis effect has worn off, the isolated portion of the cord below the level of the lesion will resume or maintain its function. The degree of its reflex activities depends on numerous factors, such as possible extension of the traumatic necrosis in the distal part of the cord, presence of associated vascular damage, co-existence of a peripheral neuropathy, the degree and duration of afferent bombardment from bedsores or an infected bladder, and finally, it depends on the general nutritional state of the body. Therefore, maintenance of function of the isolated cord will fluctuate depending on the combined effect of the above-named circumstances.

3. A third example will compare two cerebral neoplasms of different histologic type, but of approximately similar size and location—viz, an oligodendroglioma and a glioblastoma of the temporal lobe. In the oligodendroglioma, the neoplastic cells infiltrate around the neurons and essentially respect the function of the ganglionic elements. Correspondingly, the clinical features are characterized by longstanding focal seizures without increased intracranial pressure and without significant neurologic deficit.

On the other hand, the glioblastoma produces massive tissue necrosis, cerebral edema, general increase of intracranial pressure with hippocampal herniation. Here the clinical syndrome would be that of a rapidly progressive neurologic deficit with signs of mounting intracranial pressure.

In cerebral neoplasms of comparable location, then, maintenance of neural function varies greatly with different histologic types of tumor and each type has its specific clinical symptomatology and time profile. This makes the old rules of localization unreliable in the diagnosis of brain tumor.

4. It appears appropriate to discuss how function is maintained in cerebrovascular disease, particularly in arterial occlusions. The French School of Déjèrine and Foix, following the classical theory of localization, described many clinical syndromes which supposedly were caused by occlusion of specific arteries. To prove such correlation, the extent of the lesions was compared with anatomic supply areas of the arteries as could be shown by post-mortem injection experiments. We now know from experiences with arteriography and cerebrovascular surgery that the fate of cerebral function depends not only on the *site* of a vascular occlusion, be it intracranial and extracranial, but also on the dynamic state of the *entire* cerebral circulation.

Cerebral blood flow is influenced by many anatomic and physiologic variables, such as collateral blood supply, systemic blood pressure and peripheral vascular resistance. Practically all cerebral arteries have anastomoses although some, like the branches of the middle cerebral artery, receive only scanty collateral blood supply. Anatomic variations of the circle of Willis, especially hypoplasia, or even absence of some of its links, are common and greatly modify the effect of a vascular occlusion. For instance, if the proximal segment of one anterior cerebral artery is congenitally absent, the functional deficit following occlusion of the contralateral carotid artery is apt to be more severe than in a case with a normal circle of Willis.

Since, in cerebrovascular disease, the lesions are often multiple and the peripheral resistance is increased by the atherosclerotic narrowing of the entire vascular bed, the possibilities for adequate collateral supply are reduced. Consequently, the size of an encephalomalacia after occlusion will be larger here and the functional deficit more extensive.

If, on the other hand, collateral circulation is adequate, occlusion of even a major artery does not necessarily result in tissue breakdown, although it may cause at least temporary loss of function. Under

such unstable conditions, physiologic factors may tip the balance between tissue death or survival. It has been demonstrated that cerebral function can be protected by maintaining adequate blood pressure, or by reducing the metabolic requirements of the ischemic area by means of hypothermia.

Finally, some remarks may be made as to how the physician can therapeutically utilize the ability of the defective nervous system to maintain its function. This faculty depends on the dual mechanisms of compensation and substitution but, as far as I know, the central nervous system at least, has little ability of true regeneration. The performance of the normal nervous system can be enhanced and developed by training and learning. In the process of training, a specific and easily reproducible pattern of conditioned responses is achieved; learning represents the storage and re-elicitation of such patterns and their symbolic manipulation for a creative synthesis. Rehabilitation therapy employs both these methods in order to improve the functions of a person with a defective nervous system. It tries to use the preserved patterns of response by activating them through other than the customary afferent stimuli or cues, or by alternative efferent pathways. For example, the ataxic tabetic may walk more securely if assisted by vision and by devices which achieve accessory cutaneous sensory stimulation; the patient with receptive aphasia may be benefited by observing additional cues coming from the visual and kinesthetic systems; in a person with a spinofacial anastomosis there must be a re-orientation of the cortical pattern of innervation.

The marvelous adaptability of the nervous system would be unthinkable if the old fixed "point to point" localization theory were strictly true. It can be explained only by a dynamic transactional concept of neural and organismal function.

Rehabilitation of Oldsters

The hands and minds of many senile or confused elderly persons can be turned to constructive tasks, considerably easing the care of this patient group that so frequently is excluded from rehabilitation programs, University of Michigan research indicates.

Speaking at the 44th annual convention of the American Occupational Therapy Association on November 9, 1961, by Beryl W. Spencer reported that senile patients in Washtenaw, Jackson, and Kalamazoo county hospitals have been taught to make such items as breadboards, candlesticks, and toy animals.

"The fact that these are marketable helps create a feeling of individual worth in the patients, and actually gives them a purchasing power for small needs they may have," she said.

The overall result is that the patients develop a renewed interest in themselves and others around them and become easier to care for, highly significant facts in that such individuals often are hospitalized a long time.

She stated that any staff member conducting an activities program in a hospital can get senile patients interested in working if the project is carefully selected and each patient tested to determine his ability to perform a given task.

Mrs. Spencer, an ocupational therapy consultant to the county Medical Care Facilities Demonstration Project, collaborated on the research with Winifred J. Hewitt, a program assistant in the University of Michigan Division of Gerontology which, with the University Department of Physical Medicine, sponsored the project.

It is financed by the U. S. Office of Vocational Rehabilitation and the U.S. Department of Health, Education and Welfare.

Use of Tolbutamide in Pregnant Diabetics

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THE TREATMENT of diabetes with an oral drug has been a tremendous step forward, and if its use could be safely extended to include certain cases of pregnancy with diabetes the advantages of convenience and simplicity would be obvious. There have been only a few reports thus far in the medical literature on the use of tolbutamide (Orinase) in the management of diabetes throughout pregnancy.[1,2,3] We have recently had opportunity to carry two diabetic patients on tolbutamide throughout their entire pregnancy with very satisfactory results. The management of these cases was made easier, we believe, by this unique drug, and though we anticipated having to switch over to insulin therapy at some time in the course of these pregnancies we found this need did not arise.

Case Reports

Case 1.—Mrs. A. K., thirty-one years old, white, para 0010, was seen on November 17, 1958, with complaints of suprapubic crampy pain for twelve days, beginning at the time of an expected but missed menstrual period. Her last menstrual period was October 9, 1958; menses had always been regular in interval, duration and amount of flow. She had been pregnant only once in twelve years of marriage, and that pregnancy ended in spontaneous abortion. For six weeks, she had been under the care of one of us (G.J.S.) for symptoms of diabetes: recurrent skin and urinary infections and polydipsia and polyuria. Examination disclosed signs of an early pregnancy which was confirmed by a Friedman test.

Hemoglobin was 11.6 Gms., white blood count was 12,300 with normal differential, and urinalysis was normal. A two-hour postprandial blood sugar was 167 mg. per cent. She was started on stilbestrol 5 mg. daily when pregnancy was diagnosed and given 250 mg. hydroxyprogesterone caproate, the latter repeated in two weeks in an effort to reduce uterine irritability.

A definitely abnormal oral glucose tolerance curve was recorded on December 16, 1958 after three days' preparation on an 1800 calorie 300 Gm. carbohydrate diet. The results were as follows: fasting—128 mg. per cent, one-half hour—183 mg. per cent, one hour—206 mg. per cent, two hours— 187 mg. per cent, three hours—135 mg. per cent. The patient was then started on an 1800 calorie diabetic diet and tolbutamide 1.0 Gm. daily. On this regimen the blood sugar two hours postprandially remained in the range of 100 to 130 mg. per cent. Lowering of this dose resulted in considerably higher postprandial blood sugars on two occasions (159 mg. per cent and 166 mg. per cent) and the tolbutamide was thus maintained at 1.0 Gm. daily throughout the pregnancy. At no time did she exhibit either glycosuria or albuminuria. Stilbestrol was gradually increased to 25 mg. daily by the eighteenth week and maintained at that dosage until delivery. She had an overall weight gain of 22 pounds, and her blood pressure ranged from 120/70 initially to 136/70 at delivery.

At 38 weeks' gestation, the cervix was still closed and uneffaced and the fetal head was floating in right occipital transverse position. Low cervical cesarean section was done under spinal anesthesia with delivery of a normal male infant, weighing 6 pounds, 5 ounces, which did well. On the morning of surgery, she had been given 0.5 Gm. tolbutamide, and during the operation 1000 cc 5 per cent dextrose in water was given intravenously. She made an uneventful recovery and was discharged on the seventh postoperative day. Postpartum, she was taken off tolbutamide for about two months. However, two-hour postprandial blood sugars again rose to 159 mg. per cent and fasting sugars to 127 mg. per cent and tolbutamide 0.5 Gm. twice daily was resumed for control. She became pregnant again in December 1959, with an expected date of confinement, September 25, 1960. This pregnancy proceeded uneventfully with the same dosage of tolbutamide as in the first. She was delivered by low cervical repeat cesarean section on September 9, 1960 at 38 weeks' gestation of a healthy male infant, weighing 7 pounds, 2.5 ounces.

Case 2.—Mrs. T. J., para 2003, aged thirty-three, was first seen on January 6, 1959 complaining of irregular menstrual periods. During the past eighteen months, her menses had become lighter in flow, lasting only one to two days with increasing dysmenorrhea but with her usual twenty-eight day cycle. The last menses however, had been seven weeks before and rather heavy. She had had two normal pregnancies, the first fifteen years ago and the second, a set of twins, eleven years ago. She subsequently had been unable to conceive. Her appetite was very good, but she recently had lost 6 or 7 pounds. She was prone to develop skin infections, had noted urinary frequency, was

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thirsty, perspired easily, felt warm, and was quite irritable and easily upset. She had no family history of diabetes.

Examination revealed a tense and anxious white woman somewhat overweight (5 feet 8 inches, 159.5 pounds). Blood pressure was 138/70, P. 120/min. Skin was warm and there was a questionable fine tongue and hand tremor. Fundi were normal. There was a grade II systolic pulmonic murmur with split first mitral sound and slight shift of PMI to the left in the 5th intercostal space. The thyroid gland was not enlarged and contained no palpable nodules. The uterus was slightly enlarged and softened with a bluish cast to the cervix and vaginal mucosa.

Urinalysis showed 4 plus sugar; fasting blood sugar was 177 mg. per cent; serum PBI was 8.7 micrograms per cent; and basal metabolism rate was plus 48 per cent of normal. Hemoglobin was 9.6 Gm., white blood count was 12,900. Standard oral glucose tolerance test was performed several days later after preparation with an 1800 calorie 300 gram carbohydrate diet and was typically diabetic, showing the following results: fasting—144 mg. per cent, one-half hour—237 mg. per cent, one hour—273 mg. per cent, two hours—230 mg. per cent, three hours—198 mg. per cent, four hours—159 mg. per cent. Chest radiograph revealed no abnormalities.

Gestation was then at about nine weeks duration and the patient was placed on a 2500 calorie diabetic diet and tolbutamide 1.0 Gm. daily. Within a few weeks of tolbutamide therapy, she felt better, pulse slowed to 80/min., and blood pressure was 120/80, but she still had occasional nocturia and thirst. There was no further evidence of tremor. Blood pressure throughout the remainder of pregnancy averaged 110/70 and symptoms of the diabetes and hypermetabolism largely cleared. Tolbutamide dosage was regulated carefully by frequent postprandial blood sugars and by fractional urinalysis at home. Blood sugars were maintained at about 124 mg. per cent without glycosuria on a dose of 1.5 Gm. tolbutamide daily.

At eighteen weeks' gestation, the patient began having intermittent mild uterine cramps with light vaginal staining on two occasions and her physical activity was curtailed. Symptoms rapidly improved, but at twenty-eight weeks she had abrupt, painless, bright vaginal bleeding and she was hospitalized. X-ray placentography disclosed a marginal placenta previa and the remainder of the pregnancy was spent at strict bed rest at home. At thirty-seven weeks, no further bleeding having occurred, low cervical cesarean section was done under spinal anesthesia and a normal living male infant, weighing 6 pounds 14 ounces, was delivered. The patient received 0.5 Gm. tolbutamide the day before surgery, and 1000 cc. 5 per cent dextrose in water intravenously was started just before the operation. Her postoperative course was very good, and tolbutamide dosage was adjusted to 1.0 Gm. daily. She went home on her sixth postoperative day maintained on the same dosage, and all symptoms of diabetes are now controlled. Serum PBI drawn at the six-week postpartum examination was 4.4 micrograms per cent.

Discussion

It is generally advised that tolbutamide therapy be restricted to that group of diabetics over forty years of age, requiring less than 40 units of insulin daily, and having no previous history of diabetic coma or ketosis. Those who have had experience with tolbutamide in pregnancy have further advised that because carbohydrate tolerance frequently is lowered at this time one should be cautious in attempting to control the diabetic with oral sulfonylurea preparations and should therefore anticipate that the drug may become ineffective later on in pregnancy.[4,8] Insulin therapy would then become necessary. Burt who has done considerable work on carbohydrate metabolism in pregnancy concludes that, as with insulin, resistance develops in pregnancy to the hypoglycemic effect of tolbutamide.[5]

In our two cases reported here, the diabetes was managed quite smoothly and effectively with tolbutamide. By following the disease with periodic blood sugar determinations and fractional urine tests for glucose it was possible to maintain effective control in each instance. In the second case, after initial control was attained, urinary spill of sugar was rarely encountered. Perhaps the limited activity and stable caloric intake in the latter part of this patient's pregnancy contributed to the ease of her control. The symptoms of hyperthyroidism initially seen appear to have been due to a combination of early pregnancy and uncontrolled diabetes. The first patient, prior to her first pregnancy, probably would fall into that group labeled the "pre-diabetic", a group having a rather poor perinatal mortality history and better considered as diabetics than otherwise as far as prenatal care is concerned if fetal salvage is to be improved. Case 1 also illustrates the observation that glucose tolerance curve during pregnancy indicates the earliest stages of diabetes, and, whether or not this hyperglycemia reverts to normal after gestation, frank diabetes eventually becomes manifest. Thus, pregnancy becomes a sensitive index of functional reserve of pancreatic islet tissue.

It should be mentioned also that the infants in the cases presented did well. None exhibited any indication of disturbed carbohydrate metabolism as a result of the mother's disease or its therapy, nor were they of unusually large size.

These two cases emphasize another oft-noted point: diabetes frequently does not become overt until some situation of stress such as pregnancy is involved. We feel as a result of our experience with these two cases that such patients represent another possible group in which to attempt diabetic control with an oral anti-diabetic agent. At the present time, it seems best to consider that the patient's own ability to

achieve and maintain control of the diabetes is the salient determinant in deciding whether continued therapy with tolbutamide during pregnancy is warranted. As long as symptoms and blood sugar levels were satisfactorily regulated in these two cases, we felt justified in continuing with the initial management and we were rewarded with good results for mother and baby in each instance. Others have made passing reference indicating that the management of pregnant diabetics may be much easier with tolbutamide than it usually is with insulin in certain instances.[6] Our experience would seem to encourage further investigation of such cases as it appears to be a promising method of management in pregnancy for both the "pre-diabetic" and the mild or moderate diabetic of recent discovery.

Summary and Conclusions

1. Case histories of two patients are presented, in which diabetes was managed by tolbutamide and diet alone over the course of three pregnancies.

2. There appears to be a real place for tolbutamide in the management of the pregnant pre-diabetic and the mild to moderate diabetic patient of recent origin, and further work should be done to establish this opinion.

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New Hearing Research Building

The cornerstone of the world's largest medical laboratory devoted exclusively to research on hearing and deafness was laid at The University of Michigan Medical Center, Thursday, November 2.

Forty scientists, educators and businessmen witnessed the event marking construction of the $1,750,000 Kresge Hearing Research Institute expected to be completed in the 1962-63 school year.

Speakers included Stanley S. Kresge of Detroit, head of the Kresge Foundation which donated funds to construct the building, President Harlan Hatcher of the University of Michigan and the Rev. Hoover Rupert, pastor of the First Methodist Church, Ann Arbor.

Mr. Kresge, President Hatcher and Dean William N. Hubbard of the University of Michigan Medical School placed the cornerstone of the structure.

Those attending the ceremony represented the varied medical specialties that will join in the Institute's research program, the executive committee of the University of Michigan Medical School, and the faculty committee and Visiting Scientific Committee which planned the facilities and the investigative program.

Forand Program to Continue

The evening paper for September 11, 1961, carried a heading "For Medical Care." A new national organization has been founded in the nation's capital to back the administration's proposal for health care to the aged through Social Security. It is called The National Council of Senior Citizens for Health Care through Social Security, headed by former Congressman Amie J. Forand, sponsor of the much opposed Forand-type legislation. The group has a two-room headquarters in Washington, an Executive Secretary, and a Director of Organization. It has communicated with about 7,000 senior citizens.

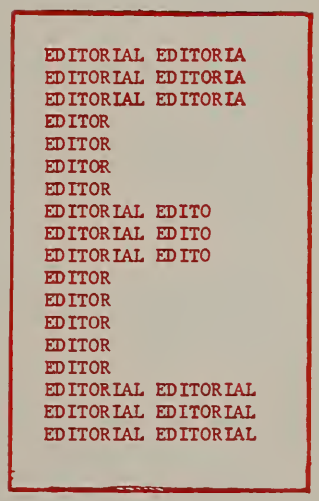
In writing replies and to help to carry on their work, the report says, there are all together 16,559,580 persons over 65 in the United States. Preliminary letters sent to 1,900 senior citizens are reported already to have netted commitments from groups with over 65,000 membership.

This movement is specifically to maintain the fight to put hospital and nursing care—not medical care—under social security. The bureaucrats are definitely trying to split the medical profession by separating pathologists, radiologists, physiatrists and anesthesiologists, exempting them from the medical profession group—but providing they can only be paid as "hospital services being rendered under the direction of the Secretary of Health, Education and Welfare."

These groups have striven many long years for recognition as Doctors of Medicine—not hospital employes. This latest "excepting" by the King-Anderson Bill has seemed to recognize a difference but only as hospital employes rendering special but not medical service. These well-recognized special medical practitioners again have been uselessly harassed.

Social Security Benefit Restriction

The Saturday Evening Post for September 2, 1961, in its lead article, comments upon a subject about which we have been writing in THE JOURNAL for more than ten years. "Why Not Let The Elderly Earn All They Can?" "A good many people believe that the restriction on earnings ought to be abolished entirely, and numerous bills have been introduced to bring this about." The SEP lists and discusses five arguments in favor and three arguments opposed, presented by HEW, and proceeds to quash them to the effect that the income to the government would not be much restricted but in return would eliminate an immense amount of unnecessary work in changing these checks every month. A cursory review shows we have mentioned some part of this problem recently: February, 1960—page 294; June, 1960—page 926; July, 1960—page 1080; January, 1961—page 85: But to go back ten years, in February, 1951 (page 190), in an editorial, "We Must Re-evaluate," we analysed this program in considerable detail in a full-page editorial.



There is actually no justification for the federal government and the Social Security department to penalize an elderly person eligible for his social security benefits because he is ambitious and willing to work to augment his meager benefits as the law now does. No insurance company would dare do such a thing, and the government would prevent such action —yet because a person works more than a specified limit, he loses his social security benefits at present.

By his very working, the individual is still contributing to the social security program. He should be praised instead of punished. This is one item which the medical profession can wholeheartedly support in the social security program. It is also one item which undoubtedly has helped convince medical men to oppose the social security program and their entrance into it. Most of them would be denied their benefits until age 72 instead of at age 65. The profession has been criticized too often as always opposing. This is another item we can support.

Income Tax Relief

August E. Johansen, Congressman from the 3rd district of Michigan, introduced a Bill (HR 9387) in the U. S. House of Representatives, locally called the Kelleher-Slagle Bill. This Bill provides that any person receiving social security benefits (the over-65-age group) after he has made out his income tax statement, may deduct from that tax whatever he has paid for voluntary medical-surgical-hospital service up to $100 in any one year. This has been referred to the Ways and Means Committee. George W. Slagle, M.D. and George T. Kelleher, M.D., of Battle Creek, will appear before the committees advocating the program which they suggested. The Bill was introduced before the recess of the House in order to get it under consideration.

The Current Status of Influenza Vaccine

It seems appropriate to try to bring some order out of the chaotic mass of information and misinformation in news releases, regarding the present status (October 13, 1961) of influenza vaccine, particularly for those in the pediatric age group.

The writer acknowledges that it is late to discuss the subject. But on the premise that the cliché, "better late than never," may apply to this short article and with the hope that it justifies the report.

On October 13, 1961, a news release from the Academy of Pediatrics, indicated that a definite stand had been taken regarding administration of influenza vaccine to patients in the pediatric age group.

After an inquiry to Academy headquarters, a wire was received and its pertinent contents are quoted below.

"It seems appropriate for a statement to be issued by the Academy . . . there is no outbreak of influenza any place in the world. . . . Until such time as an outbreak is reported by the World Health Organization surveillance, it seems wise *not* to recommend *routine* immunization (for influenza) for children. . . . (Doctors) should be guided by the general statements included in the "Red Book." If an outbreak is reported an emergency statement will be forthcoming."

The 1961 "Red Book" is an official guide, developed by the Academy of Pediatrics. The following paragraphs condense the general advice given regarding influenza vaccine.

As *a routine practice,* the use of the above vaccine is recommended for persons of all ages who suffer from chronic cardiovascular, pulmonary, renal or metabolic disorders. This includes heart disease of all types, chronic broncho pulmonary diseases, diabetes, Addison's disease and similar debilitated states, also pregnant women.

In years . . . of high incidence the following groups hold high priority: infants three months to one year, persons over seventy years, key personnel in the fields of medicine, business, industry, transportation education and communication. Because of high incidence in some epidemics, people from five to twenty-five years of age are included.

Further the "Red Book" cautions, that persons who are known to be allergic to egg or chicken, or those who have had allergic responses when egg grown vaccine has been administered previously, should not be given this product.

In the future, a dynamic and prompt action by a major health committee should help to avoid the inaccuracies and lack of agreement in medical and lay press releases.

A. Morgan Hill, M.D.

October 25, 1961

Annual Session

The Annual Session of the Michigan State Medical Society for the year 1961, was undoubtedly one of the most important we have had in many years. The scientific papers were of unusual interest, very well presented before large groups practically filling the

auditorium space. Many of these papers were extremely significant in proposing lines of thought and investigation to the audience. They reported research which is renewing and definitely improving the chances of survival of our patients in the future.

Many new facts and procedures were outlined, new investigations suggested, reports of comparatively recent work given, so that most of us came home proud of our profession, proud of its accomplishments and stimulated to add our own contributions to those already made. In the last ten years, the life span has been increased probably one or two years, maybe more. We are confident that at our "Centennial" in 1965, we shall have attained the ambition outlined a year ago by the "Presidents Program" which proposed to add five useful years of life to our citizens. From reports, that goal seems already to have taken fire, and we are in that process. Extended years, the senior years, beyond the unrealistic government proposed retirement date for our citizens are already showing their value and justification.

Elections

The Michigan State Medical Society has selected Clarence I. Owen, M.D., Director of Laboratories of Grace Hospital, Detroit, as President-Elect, and promoted Otto K. Engelke, M.D., Ann Arbor, to President. James J. Lightbody, M.D., Detroit, was re-elected Speaker of the House, and Harold F. Falls, M.D., Ann Arbor, was re-elected Vice Speaker of the House.

In the Council, there were more than the usual number of changes. A. E. Schiller, M.D., Detroit, resigned as Councilor of the 1st District; H. I. Meier, M.D., Coldwater, resigned as Council Chairman and Councilor from the 3rd District, and T. P. Wickliffe, M.D., resigned as Councilor of the 13th District. The House of Delegates also recognized the increased population in doctors and delegates from Wayne County. It established a new rule cancelling District 16, 17 and 18 and, in District 1, establishing the provision that where there is a concentration of delegates, that county shall have one Councilor for each ten delegates. That ruling gives Wayne County five delegates instead of four as in the past. The House of Delegates thereupon selected William S. Carpenter, M.D., Detroit, to succeed Dr. Schiller and Edgar E. Martmer, M.D., as the fifth Councilor from Wayne. Harvey C. Hansen, M.D., Battle Creek, was selected Councilor to succeed H. I. Meier and D. Raymer Smith, M.D., Iron Mountain, to succeed Dr. Wickliffe, term expiring in 1963. William A. Scott, M.D., Kalamazoo, C. Allen Payne, M.D., Grand Rapids, H. H. Hiscock, M.D., Flint, were re-elected for the 4th, 5th and 6th Districts.

AMA Delegates

J. S. DeTar, M.D., Milan, declined re-election as delegate to the AMA, and John Heidenreich, M.D., was selected in his place. Wm. A. Hyland, M.D., Grand Rapids, and O. J. Johnson, M.D., Bay City, were re-elected. Luther R. Leader, M.D., Detroit, was selected for the fourth vacancy, President-Elect C. I. Owen, M.D., being transferred to alternate delegate. Warren W. Babcock, M.D., Detroit, withdrew. G. B. Saltonstall, M.D., Charlevoix, John M. Wellman, M.D., Lansing, B. M. Harris, M.D., Ypsilanti, were re-elected as alternates. Robert E. Rice, M.D., Greenville, and Sydney Adler, M.D., Detroit, were selected to fill other vacancies as alternate delegates.

The Council met to reorganize on Thursday morning, September 28, selecting Oliver McGillicuddy, M.D., Lansing, as chairman; O. J. Johnson, M.D., Bay City as Vice Chairman; Warren M. Babcock, M.D., Detroit, as chairman of the Finance Committee; R. J. Mason, M.D., Birmingham, chairman of the County Societies Committee, and William A. Scott, M.D., Kalamazoo, chairman of the Publication Committee.

Clarence I. Owen, M.D.— President-Elect

The President-Elect of the Michigan State Medical Society, Clarence I. Owen, M.D., Detroit, was born in New Hampshire in 1896. He attended Detroit Western High School and received his medical degree from Wayne University in Detroit in 1920. He is the father of two children and has four grandchildren. His son, William, now deceased, received his medical degree from Wayne in 1952.

Since his graduation from Wayne University Medical School, Doctor Owen has been Pathologist to and Director of the Laboratory of Grace Hospital in Detroit. He is a Diplomate of the American Board of Pathology in Anatomic Pathology and Clinical Pathology, and is a member of Phi Rho Sigma medical fraternity.

He served as Secretary and Treasurer of the Detroit Academy of Medicine from 1956 to 1959, and as President in 1960-1961. As a member of the Wayne County Medical Society, he was the first President of Noon Day Study Club (1927-1928), serving as President in 1958-1959. He was a Delegate to the Michigan State Medical Society from 1946 to 1961, and Editor of *Detroit Medical News* from 1960 till the present time.

He was elected by the Michigan State Medical Society to serve as Alternate Delegate to the American Medical Association from 1946 to 1955 and was a Delegate from 1955 to 1961. He is a member of the

Association of Military Surgeons, the American Medical Association, American Association of Pathologists and Bacteriologists, Michigan Pathological Society (serving as President in 1936-1937), American Society of Clinical Pathologists (Vice President, 1930-1931), Executive Committee (1932-1935), Fellow, College of American Pathologists.

He has had some twenty-five to thirty articles published in national medical journals and *Grace Hospital Bulletin*, many of which were case reports, some original research. From 1921 to 1950, he served on the teaching staff of the Department of Pathology at Wayne University, was a member of the Executive Committee Alumni Association of Medical College (1930-1933), member of Board of Governors, Alumni Association of Medical College (1955-1958), member Board of Governors of Alumni Association of University (1960-to date).

He served for more than five years in World War II, many years in active reserve, and retired as a Colonel MC (AUS). He received a Commendation Ribbon. He is a member of Retired Reserve of the Selective Service System.

He is an Elder in the Presbyterian Church, a member of the Detroit Rotary Club, Detroit Commandery No. 1 Knight Templar, is currently the medical advisor to the Michigan State Director of Selective Service. He has given numerous talks before service and other clubs.

Mrs. Owen is President of the Women's Auxiliary of the Michigan State Medical Society.

Michigan Medical Service

The corporate body of Michigan Medical Service, which consists of the seated House of Delegates of the MSMS and the non-delegate members of the Board of Michigan Medical Service, held its annual meeting Tuesday afternoon, September 26, 1961. The most important business was the election of the Board of Directors. The following were elected for a three-year term: Representing the Michigan State Medical Society; F. S. Alfenito, M.D., Grand Rapids; E. C. Baumgarten, M.D., Grosse Pointe Woods (he had been a member several years previously); Robert M. Bookmyer, M.D., Birmingham; Hugh Caumartin, M.D., Saginaw; G. Thomas McKean, M.D., Detroit, (re-elected); John M. Wellman, M.D., Lansing (re-elected); Alfred H. Whittaker, M.D., Detroit (new member). Representing the Michigan Hospital Service: Mr. Franklin D. Carr, Detroit, and Ralph C. Hutchins, Alma (both re-elected). Representing the Public: Rt. Rev. Robert L. DeWitt, Episcopal Diocese, Detroit (new member) and Mr. Waldo I. Stoddard, Grand Rapids (re-elected). This makes four completely new members representing the medical profession and one new member, the public.

At the close of the election, Mr. Sumner Whittier, Executive Vice President and Director, made some most thrilling, interesting and challenging remarks about Michigan Blue Shield, its history, accomplishments and capacity for immensely increased service. It is the accomplishment of unusually dedicated men of medicine in Michigan with whom he chose to work, believing as he does the challenges of the next months will be increased by the announced programs of the administration.

Mr. Whittier's talk was received with rapt attention and a rousing standing approval.

Full Information

Effective March 5, 1962, a regulation of the Federal Drug Administration will require drug manufacturers to provide the medical and pharmaceutical professions with more information in the labeling of drugs and devices that are sold only on prescription.

This will be done by means of a package insert, which is nothing new. However, it is the intent of the regulation that the manufacturer will describe fully any and all toxic effects and side reactions that might be encountered in the use of the product.

Objections had been raised against this regulation. One objection was that it would increase the cost. Anyone familiar with publishing and printing knows that in large volume orders the addition of a few paragraphs amounts to very little in cost. As regards cost of preparation, one would expect that the existing staff could handle this without too much expansion. The cost of frankness should be minimal.

Another objection was that the inserts might fall into the hands of untutored lay persons with undesirable consequences for both the patient and the physician. This of course is the responsibility of the physician and the pharmacist—the physician to see that the printed matter is destroyed before disposal and the pharmacist to dispense in accordance with the prescriber's instructions.

By this regulation the consciences of government and manufacturer are clear, and the choice of drug is put squarely up to the physician where it belongs. Acting on full information, he must weigh the therapeutic effect he desires against the possible hazards.—*New York State Journal of Medicine*, Nov. 15, 1961.

Correction

In the August issue, the photograph of A. D. Ruedeman, Sr., M.D., was used by mistake with the paper by A. D. Ruedeman, Jr., M.D.

In the article by Louis B. Gariepy, M.D., his father's picture was used. We are sorry for these mistakes, and we are making every effort to see that this does not happen again.

Medical Schools Expand in U.S.A.

The warnings by well-known medical educators that the nation must increase the number of medical school graduates in order to maintain the present physician-population ratio are beginning to yield some tangible results.

Rutgers and Brown Universities have announced plans to offer two-year programs in the basic medical sciences. The University of New Mexico is making strides toward starting a two-year program in the basic medical sciences.

San Antonio, Texas won a drive to locate a medical school in that city recently when a deed for 100 acres of land for the school was presented to the University of Texas. The state legislature has appropriated $1.85 million to begin the medical school.

While states such as Maine, Massachusetts, Minnesota, Idaho, Ohio, and New York are studying the possibilities of establishing new medical schools, the Connecticut Legislature went into action by appropriating $2 million to help start a new medical-dental school to be affiliated with the University of Connecticut. This amount, coupled with a $1 million grant from the Kellogg Foundation, will enable the university to actively start work on the four-year medical school.

The University of Arizona has been selected by the Board of Regents as a medical school site, "if and when funds are available."

Latest reports from California reveal that the Board of Regents of the University of California have under serious consideration plans for a four-year medical school for the proposed new university campus at San Diego.



Seek Mission Doctors

The willingness of American doctors of medicine to serve in foreign mission fields on a temporary basis is shown by the large number of doctors who have written recently to the AMA. The AMA is helping doctors volunteer for service in the foreign mission fields on a temporary basis when emergencies arise. Cooperating in this program are missionary agencies representing every denomination sponsoring American medical missionaries.

Physicians interested in volunteering for such service are asked to write directly to the AMA Department of International Health, 535 N. Dearborn Street, Chicago 10, Illinois.

No Finer Opportunity

Early in the Kefauver hearings, the subcommittee invited testimony from the Arthritis and Rheumatism Foundation. There followed appalling disclosures that some $250 million are spent each year by arthritics on useless quack cures. . . . Considering the close attention of the press and public to these proceedings, never had a Congressional inquiry been handed a finer opportunity to launch a public

crusade and mobilize national resources to stamp out criminal operatives in the health field. And what happened? Nothing. The investigators were far more interested in getting back to the assault on manufacturers of cortisone and its derivatives which have actually restored millions of cripples and potential cripples to useful, productive life.—*Report to the Nation:* Austin Smith, M.D., President, Pharmaceutical Manufacturers Association.

Continuing Education Stressed

The importance of continuing education has received increasing recognition in recent years, primarily because of the tremendous expansion in medical knowledge. The modern physician is confronted by what often seems to be an impossible task in attempting to keep himself informed of the latest developments. In spite of his best efforts at reading the medical journals and attendance at an increasing number of scientific meetings, he is likely to find himself well behind the advancing research teams. His only hope of catching up would appear to be a series of well-designed programs, developed by leaders in medical education.—From an editorial in JAMA, August 12, 1961, Page 444.

To Draft 400 Medics For Military Service

The Armed Forces plan to draft up to 400 physicians in the near future, with most of them slated to serve in the Army.

Physicians who completed internships last July will be affected.

The Army also issued a clarification on the residency training status of medical reserve officers liable for call to active duty as members of alerted reserve units.

Voluntary participants in the "Berry Plan" and reserve officers commissioned through the ROTC program, who previously had been granted delays to complete their medical educations, will be transferred from alerted reserve units to the United States Army Reserve Control Group (Delayed).

Reserve medical officers in fulltime residency training who are not Berry Plan participants may be delayed from call to active duty if they can complete the final year of any accredited residency program within nine months from October 1.

Seek Funds for Second S. S. Hope Ship

The People-to-People Health Foundation, sponsor of the *S.S. Hope* floating hospital and medical school, plans a campaign to raise $10 million for future projects.

The *S.S. Hope* recently arrived back in San Francisco after a year in southeast Asia. Latin America is scheduled as the next stop. If the fund-raising goal of $10 million is reached, a sister ship to the *S.S. Hope* is planned.

Over $2 million has been collected by the Foundation and an additional $2.5 million worth of gifts in kind—drugs, equipment—was contributed. This has all been put into People-to-People projects, including the *S.S. Hope* and the three hospitals the foundation staffs and operates in Asia. One hundred U. S. physicians have voluntarily aided overseas with these projects.

The concept of a goodwill floating hospital and school has grown. Britain and Scandinavia are planning large ships such as the *S.S. Hope,* and Indonesia will soon have a smaller ship of this nature serving there.

Ten Areas of Primary Concern to the AMA

(As Cited by Dr. Blasingame at AMA Institute in Chicago)

1. Attracting additional members into organized medicine.
2. Seeking even better programming for AMA annual and Clinical Sessions.
3. Continuing the improvement in undergraduate medical education.
4. Continuing and expanding postgraduate medical education.
5. Fostering medical scientific research.
6. Emphasizing medical ethics.
7. Exerting leadership in attacking any wastage in medical care costs.
8. Increasing the quantity and quality of the research into many vitally important phases of medical economics and insurance.
9. Continuing the fight to protect American medicine's freedom of practice.
10. Demonstrating AMA's interest and cooperation in the field of international health.

Report on Congress Presented by AMA

There were 14,026 bills introduced in the First Session of the 87th Congress and of those bills 555 were of interest to medicine.

The American Medical Association submitted statements on nine of the bills offered. Four statements were in favor; three in opposition; and two informational. The AMA supported H.R. 1341, safety devices on government purchased automobiles; provisions of S. 1072 dealing with medical school construction; H.R. 10, a tax-deferred retirement plan for the self-employed; and appropriations for the Civil Defense Shelter Program. AMA submitted statements in opposition to the King bill (H.R. 4222); the Kefauver drug bill (S. 1552); and H.R. 6471 on drug advertising.

Statements filed for information were those on the Constitutional Rights of the Mentally Ill and the Exchange Student Program.

* * *

The following bills of medical interest became law during the First Session, 87th Congress: H.J. Res. 306, a posthumous medal for Thomas Dooley, M.D.; H.J. Res. 358, establishing an annual poison prevention week; S. Res. 154, an expression of the Senate favoring the establishment of a Great White Fleet to provide medical care and other aid at times of natural disaster; S. 336, providing grants for training of teachers of the deaf; S. 1922, increasing the mortgage guarantee of nursing homes from 75% to 90%; S. 2237, making permanent the provisions under which certain immigrants with tuberculosis may be admitted to the U. S.; H.R. 3980, amending the Food Additive Law to provide transitional provisions; H.R. 4884, which had a provision under which the Federal Government could increase its contribution for medical care under Old Age Assistance from $12 to $15; H.R. 4998, the Community Health Facilities and Services Act, and H.R. 6441, the Water Pollution Control Act.

* * *

What the Press Said . . .

After the first session of the 87th Congress adjourned, the press made many comments about the proposed compulsory social security medical aid for the aged plan. Among these were:

The Chicago Daily News

"Congress was right, too, in bypassing the Administration's proposal to impress the nation's older people into a medical program under Social Security."

The New York Times

"The White House ducked a fight on its controversial proposal to give medical care to the aged under Social Security. This will be on the election year calendar when Congress reconvenes."

The Wall Street Journal

"Amid the dying echoes of the current Congressional session, one fact emerges startlingly clear: The Kennedy Administration faces a crisis in leadership in the increasingly conservative House of Representatives."



"Next Session," Says McNamara

The following are consecutive paragraphs taken from Senator McNamaras September "Report to the People of Michigan":

"A few weeks ago, I discussed this matter with President Kennedy at the White House and followed up our conversation with a letter in which I urged an early start on planning for this vital legislation next year.

"In his letter of response, the President said in part . . . 'I agree wholeheartedly with your belief in the importance of this legislation to our nation . . . and I assure you that I intend to recommend that this legislation be given the highest priority at the next session of Congress.'

"So I am hopeful that we will get an early and successful start on medical care for the aged when Congress returns in January."

Supports Drug Industry

"Another layer of federal laws on top of existing legislation governing the drug industry would do little, if anything to reduce drug costs."

So stated Harry E. Carnes, M.D., of Parke, Davis & Company, at the recent scientific meeting of the Nebraska chapter, American Academy of General Practice.

"Has the drug industry done so poorly for the peoples of the U. S. and the world as to merit attempts by segments of the government to stifle and ultimately control the pharmaceutical industry?" he asked.

Medical research, he said, has helped to increase life expectancy, cut down on infectious disease deaths by 75 per cent since 1938, reduce the occupancy of mental hospitals due to tranquilizers, brought the closing of TB sanatoria due to effective drugs; and developed the hormone drugs which have been successful in treating the arthritic patients.

Dr. Carnes said that he hopes that when the "dust settles medical practice, research and pharmaceutical developments will still be securely in the hands of those who are best qualified to manage such affairs."

Explains NAM Concern to Kent Physicians

Charles R. Sligh, Jr., of Holland, Executive Vice-President of the National Association of Manufacturers, addressed the recent meeting of the Kent County Medical Society, and made these statements:

"Your opposition to the Administration's social security-medical aid proposal is unreserved, and you may wonder why an organization of 18,000 manufacturers, mostly small business men, should insist on pitching into the battle on your side. You might think we would have enough to do in matters closer to the personal and business interests of our members.

"Yet, we have testified in Congress against this bill. We have widely publicized our oppositions to it in a planned campaign.

"We have come to your side because you are fighting a battle against socialization of medical practice, and we feel that we must fight every attempt to nationalize America's private affairs, no matter where they occur."

A Businessman Speaks . . .

Robert P. Briggs, chairman of the board of directors of the Federal Reserve Bank of Chicago, recently said:

"I happen to be a businessman who believes many of us, if we really try, can do a better job than we are doing in fulfilling our responsibilities to the business community and to our businesses; who believes that we as businessmen must stand up and be counted on public issues; who recognizes that government is essential and that we had better improve it; and who believes citizenship responsibilities cannot be ignored.

"An effective place for businessmen to communicate their ideas is in the political arena. More and more businesses are urging their employes to become active in politics. It is not enough to contribute dollars to the party of your choice. Participation in the councils, working in the campaigns, and even being candidates for public office are essential if democracy is to have the full advantage of your time and talents."

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1962 MAP Congress at MSU To Feature Carl Winters

Rev. Carl S. Winters, one of America's finest speakers, has accepted an invitation to give the main address of the President's Dinner-Dance at the 3rd Annual Congress of the Professions, Saturday, February 9 and 10, 1962.

As a "jet-circuit-rider" on the lecture staff of the General Motors Corporation, Dr. Winters has achieved an international reputation as a foremost inspirational speaker and humorist. His Congress address will be entitled "Your Ethics Are Showing."

Dr. Harlan Hatcher, president of the University of Michigan and Dr. John Hannah, Michigan State University president, have been invited to address noonday meetings of the Congress. Dean Edward A. Carlin, University College, MSU, is working with the Congress Planning Committee in securing name speakers to address the Congress at sessions devoted to "great thoughts."

MAP Studies Services

The MAP Committee on Business Services and Techniques is researching into several new business services to be offered its members in 1962.

It is expected that the first of these to be completed will be the Investment-Retirement Program reviewed previously in the JOURNAL. An entirely new concept in retirement planning, the program conceived will combine the advantages of two distinct and very different types of investment: the common stock which will offer growth possibilities along with current interest earnings and annuities that will offer an income that cannot be outlived plus the guarantee of principal.

The Committee will conduct a survey among MAP members to determine their thinking on this type of investment-retirement and finalized plan will be presented early in 1962.

Other plans include a Gift Purchase Plan wherein MAP members could purchase gifts at an economic savings; and a Travel Plan through which MAP could offer travel service by a tie-in with an established travel service bureau that would provide "group" transportation and travel plans at rates that would result in considerable saving. Such service, for the most part, would be directed to group travel to conventions or travel outside the United States.



ANCILLARY 1455

Detroit News Fund Aids Medical Students

Ten students, named by the medical schools of the University of Michigan and Wayne State University, will receive $500 grants each

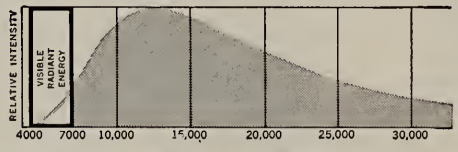


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from *The Detroit News* Medical Aid Fund, now in its second year. The grants were made through the deans of the medical schools to second or third year medical students who demonstrated need and ability.

The winning University of Michigan students, each a winner for the second consecutive year, are Lynn Ellen Dykeman, Grand Rapids; William Duer Burton, Ann Arbor; David Keith Hickok, Plainwell; John Raymond Ladd, Midland; and Donald Duane Worchester, Big Rapids.

The Wayne State University students are Helen Hutula Winkler, Austin A. Aardema, James H. McCarthy, John R. Shearer, and Allen Joseph Telmos, all of Detroit.

Finances Cancer Research

More than $80,000 in grants for cancer research in Michigan hospitals and medical colleges has been expended so far this year by the Michigan Cancer Foundation.

Oscar D. Stryker, M.D., St. Clair Shores, chairman of the Foundation's medical and scientific committee, reports that funds earmarked for the furtherance of cancer research will exceed $100,000 for this year.

Besides individual grants to scientists, the Foundation has expended $3,600 in summer scholarships for high school students interested in cancer research.

Nurses Name Executive

Eleanor M. Tromp, R.N., Lansing, has been appointed executive secretary by the board of directors of the Michigan State Nurses Association.

Miss Tromp, a former Grand Rapids public health nurse, rejoins MSNA after a year's leave of absence during which she earned her master's degree at Teachers College, Columbia University. She first joined the MSNA staff in 1956 as assistant executive director and has been responsible for the association's legislative program.

Hospital Auxiliaries Study PR

Public relations and its importance in the hospital field were stressed at the 13th annual workshop of the Michigan Association of Hospital Auxiliaries held recently at Gaylord. Nearly 300 delegates attended.

Guest speakers were George E. Cartmill, Jr., director of Harper Hospital, Detroit, who discussed "Administration and the Volunteer," and Roger M. Busfield, public relations director of the Michigan Hospital Association. Four other programs dealt with "Programming and Communication," "Community Participation in Fund Raising," "The Role of the Volunteer," and "Citizens for Scholarships in Health Careers."

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MICHIGAN DEPARTMENT OF HEALTH
ALBERT E. HEUSTIS M.D., State Health Commissioner

Upswing in the Influenza Cycle

The Public Health Service has reported that an upswing in the influenza cycle is very likely to occur in this country during the coming winter.

It is the opinion of the Public Health Service that we are probably due for some Asian influenza outbreaks which usually come in two- to three-year cycles, and we are also overdue for Type B influenza outbreaks which usually occur in four- to six-year cycles. Asian influenza has been dormant in this country since March, 1960, and it has been more than six years since we have had any substantial numbers of Type B influenza.

The Michigan Department of Health therefore recommends immediate influenza vaccinations for all persons in the three groups which accounted for most of the 86,000 flu-triggered deaths between September 1957 and March 1960. These groups are: persons with heart disease, pulmonary disease, diabetes, and other chronic illnesses; persons over sixty-five years of age; and pregnant women.

In Michigan, people in these groups were the primary victims among the 657 deaths directly attributed to influenza during the past four years. In a great many other deaths, the onset of influenza was a significant contributory factor. Most of these deaths could probably have been avoided if people in these high risk groups had been vaccinated. However, once influenza has broken out in a community, it is too late for effective protection.

In addition to the above recommendations, the department also recommends routine annual immunization against influenza for all people in high risk groups. These groups are defined as (1) patients with chronic diseases of heart and lungs, diabetes or with other chronic diseases in which influenza would pose an added health risk; (2) pregnant women and infants; (3) persons over age 65. The department further recommends influenza vaccination on an annual basis for those persons responsible for the care of the sick—hospital and nursing home personnel, physicians, nurses, public health personnel, and those responsible for providing essential public services.

The recommended dosage for initial immunization is two injections, 1 cc. each (500 cca units per cc.) administered subcutaneously two months apart. Persons previously immunized with polyvalent vaccine should receive a booster dose of 1.0 cc subcutaneously each fall, prior to November 1. Persons with a history of sensitivity to eggs, chickens, or feathers are cautioned to inform their physician or this fact, and be guided by his advice as to whether or not they should receive the vaccine.

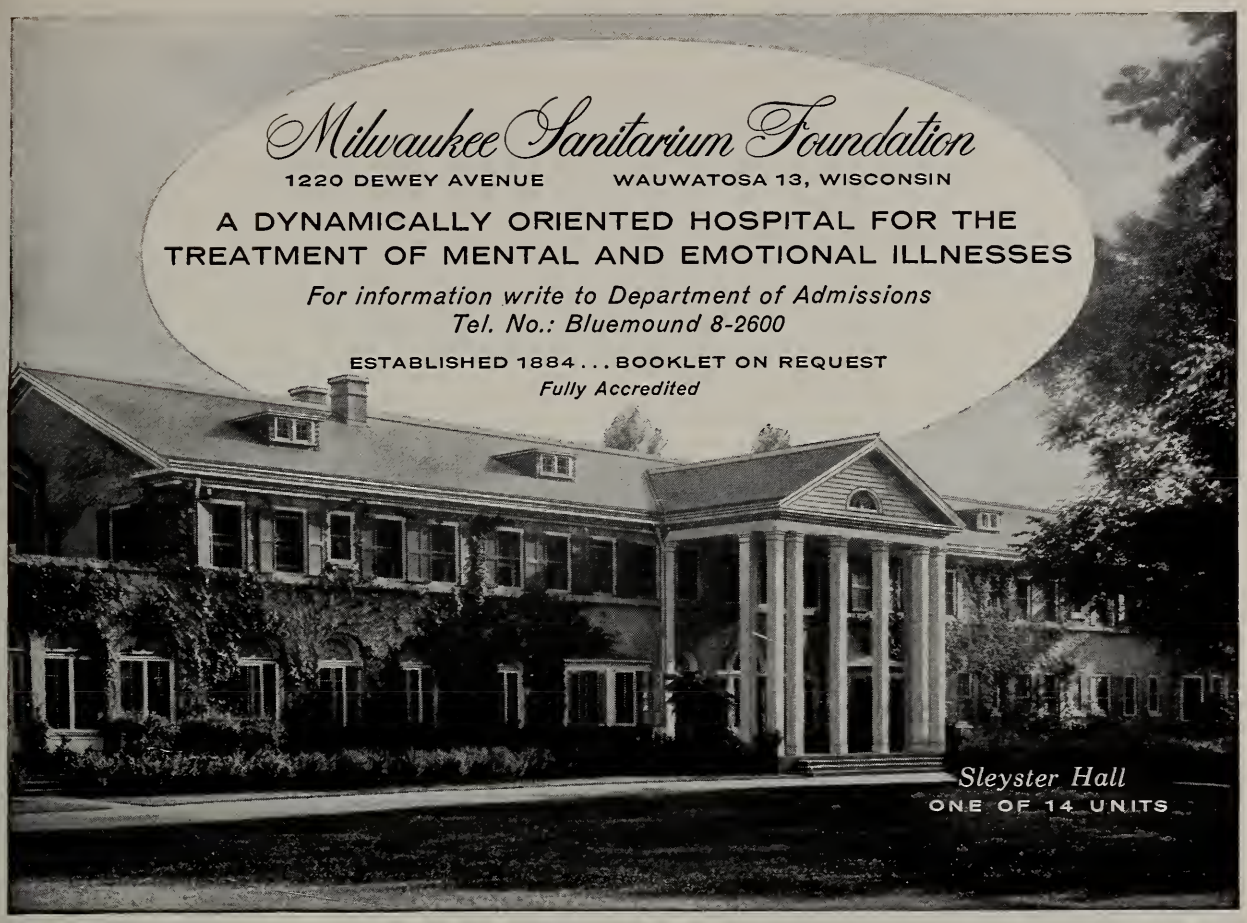
The Michigan Department of Health does not provide influenza vaccine.

Polio Progress Report

All indications are that as of the first nine months of this year, the incidence of paralytic poliomyelitis in Michigan has reached an all-time low. As of the end of September, only 14 cases have been reported. This compares with 34 cases in the same period of 1960, and with 1,581 cases reported at this time during the record high year of 1952. On the basis of these figures, it would appear that we may be approaching a point where poliomyelitis is virtually nonexistant as a cause of crippling and death. Since the passage of the Check Point Immunization Law last year, we are pretty well assured that the vast majority of all children entering school for the first time will be protected against poliomyelitis as well as smallpox, diphtheria, tetanus, and whooping cough.

However, there is still a problem with regard to preschool children. Records indicate that of the fourteen paralytic cases this year so far, six (just under one-half) were under six years of age, five were over twenty years of age, and only three between the ages of six and twenty. Of these, five had no immunization at all, five had less than three shots, three had three or more shots, and the immunization status of one is not known.

It is obvious that the preschool group is still the one most vulnerable to attack by crippling poliomyelitis and it is to this group that we must address our most earnest efforts if we are ever to really eliminate the needless crippling and death caused by this disease.





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HEART BEATS

(This material is provided by the Michigan Heart Association)

Michigan Heart Association

The annual "Michigan Heart Day" of the Michigan Heart Association will be held at the Statler-Hilton Hotel, Detroit, Michigan, February 10, 1962. The scientific program will be as follows:

A.M.

9:00 E. Cowles Andrus, M.D.
Past President, American Heart Association

9:45 J. Scott Butterworth, M.D.
President-elect, American Heart Association
"Auscultation of the Heart"

10:30 Intermission

10:45 F. D. Johnston, M.D.
Professor of Medicine, University of Michigan
"Electrocardiogram in Cononary Disease"

11:15 F. Mason Sones, Jr., M.D.
Cleveland Clinic
"Angiocardiography in Coronary Artery Disease"

Noon Luncheon, Annual Meeting of the Michigan Heart Association.
Election of Board of Trustees.

P.M.

2:00 Panel: "Unexplained Big Heart"

(1) Melvin H. Kaplan, M.D.
Cleveland Metropolitan General Hospital
"Concept of Autoantibodies to Heart"

(2) Otto Saphir, M.D., Director, Department of Pathology
Michael Reese Hospital, Chicago
"Pathological Aspects"

(3) Panel Discussion:
Drs. Kaplan, Saphir, Andrus, Butterworth, Sones, Johnston, and Robert Ziegler.

Grants-in-Aid

Applications for Michigan Heart Association Grants-in-Aid for the fiscal year 1962-63 are now being accepted. The deadline date is December 15, 1961. For further information, contact Medical Director, Michigan Heart Association, 3919 John R. Street, Detroit 1, Michigan.

ANNUAL CLINICAL CONFERENCE

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Brief, And On Target

PRESIDENT FROM MICHIGAN—Traian Leucutia, M.D., has been installed as president of the American Roentgen Ray Society. Dr. Leucutia is director of the Division of Radiation Therapy at Harper Hospital in Detroit and assistant professor of radiology at the Wayne State University College of Medicine.

A native of Romania, Dr. Leucutia received his medical degree from the University of Budapest in 1916 and attended post-graduate studies at the University of Paris and Cambridge University in England. He completed his residency in radiology at Harper Hospital in Detroit in 1924.

* * *

PRESENTED AWARD—William L. Brosius, M.D., Detroit, has been honored for his technical contributions in the battle against tuberculosis. He received from the Michigan Thoracic Society the Bruch H. Douglas Award, founded in memory of Detroit's former health commissioner. The award is made annually to a person who has made an outstanding contribution in the field of tuberculosis.

* * *

HONORED—John R. G. Gosling, M.D., Ann Arbor, has received a $500 Distinguished Service Award from the University of Michigan. Made possible by the U-M Chicago Alumni Club, the award lauds his work at the University of Michigan School of Medicine.

* * *

SAMA INVITES EXHIBITS—Medical students, interns and residents desiring to have their scientific exhibits shown at the 12th annual convention of the Student American Medical Association, May 9-13, 1962, in Washington, D. C., should file their applications early, according to Russell F. Staudacher, executive director of the Student American Medical Association. Under the new rules for the SAMA-Lakeside Scientific Exhibit Assembly, only 24 exhibits will be accepted for showing at the 1962 Convention. All will compete for the 1962 Lakeside Awards.

* * *

PRESIDENT-ELECT—At their recent annual meeting in Cleveland, M. K. Newman, M.D., Detroit, was made president-elect of the American Academy of Physical Medicine and Rehabilitation. Doctor Newman also presented a paper at the American Congress of Physical Medicine and Rehabilitation in Cleveland, entitled "Clinical Aspects of Pain: Electromyographic, Plethysmographic and Dermohmmetric Studies with Reference to Trauma and Control Patients."



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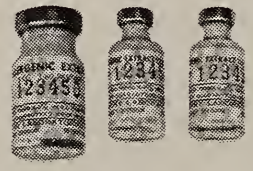
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FELLOWSHIPS EXTENDED—The Association of American Medical Colleges has announced the extension of the Foreign Fellowships for Medical Students program which is sponsored by Smith Kline & French Laboratories, Philadelphia pharmaceutical firm. Originally set up for a three-year term and due to expire in 1962, the program is to be extended through 1963. Applications are being accepted, and will be processed in February, 1962. Students should obtain application forms and instruction sheets from their deans.

* * *

CITED AS VOLUNTEER—The Michigan Tuberculosis Association named a past president, Max L. Lichter, M.D., Melvindale, as its "Outstanding Volunteer of the Year" and honored him at the 54th annual meeting in East Lansing. Dr. Lichter served as president of the Christmas Seal organization from 1957 to 1959 and also as Wayne County campaign chairman on several occasions.

* * *

GIVES CANCER TALK—Herbert J. Robb, M.D., Allen Park, on behalf off the Michigan Cancer Co-ordinating Committee, recently addressed the Gratiot-Isabella-Clare County Medical Society at Mt. Pleasant. His subject was "Modern Surgical Procedures in Cancer."

* * *

HONORED—E. I. Carr, M.D., Lansing, has been elected chairman of the board of trustees of the United States Section, International College of Surgeons.

* * *

WINDSOR MEETING—The Annual Meeting of the Ontario Medical Association will be held in Windsor, Ontario, with the scientific sessions beginning May 14.

* * *

NEW RESEARCH CENTER—The University of Michigan and the School of Public Health jointly will establish a "Center for Research in Diseases of the Heart and Circulation and Related Disorders." The Center will be financed by a seven-year program project grant from the U.S. Public Health Service totalling about $500,000 per year. The program will be carried out in field stations, laboratories and other existing buildings. No additional physical facilities are planned at this time.

* * *

NAME CHANGED—Members of the Michigan Tuberculosis Association voted a constitutional change in the name of their organization at the 54th annual meeting in East Lansing. The new name is "Michigan Tuberculosis and Respiratory Disease Association." The change in name coincides with a growing program of research into the field of respiratory diseases such as emphysema, asthma, bronchitis and histoplasmosis. The change was recommended by a committee which included many representatives from the field of medicine.

* * *

AUTHOR—Vlado Getting, M.D., Ann Arbor, contributed to two documents on community health practice just published at the University of Michigan.

* * *

ASSIST COACHES—Four doctors served as consultants for a session at the one-day Athletic Injury Conference for high school coaches, trainers and team physicians



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at the University of Michigan. The four specialists included Doctors Robert Bailey, George Koepke, Marvin Pollard and Richard C. Schneider, all of Ann Arbor.

* * *

GIVEN "DSA"—Leslie V. Burkett, Flint City and Genesee county health officer, was selected at the fall Michigan Health Officers Association to receive a "Distinguished Service Award." The award recognizes his "lasting and outstanding contributions to public health in Genesee County and in the State of Michigan." He has been active in the Council of Hospital Survey and Construction, and is a former president of MHOA and the Michigan School Health Association.

* * *

LONG SERVICE CITED—Frank T. Moran, M.D., of Romeo, recently received a 20-year service pin from the Mount Clemens Selective Service Board for his long service.

* * *

HONORED AT MARQUETTE—Lloyd W. Howe, who has practiced at Marquette since 1915, was given a plaque by St. Luke's Alumnae Association there recently "for years of devoted service and guidance" to St. Luke's Hospital.

* * *

DOUBLE DONORS—Sheldon Kantor, M.D., now in his residency at Sinai Hospital, Detroit, named the "Outstanding Intern of the Year" and also first award for his scientific paper at the hospital alumni day program.

* * *

MEETINGS LISTED—Detroit Oto-Laryngological Society announces the following meeting dates: December 20, 1961; January 17, 1962; February 21, 1962; March 21, 1962; April 18, 1962, (Joint Meeting at Ann Arbor, University Staff); May 16, 1962, (Harper and Receiving staffs).

* * *

CLINICAL CONFERENCES—The second or third Wednesday of each month, October, 1961 to April, 1962, at the University of Michigan Medical Center: December 13, Urology; January 10, 1962, Neuro-surgery; February 14, 1962, Surgery; March 14, 1962, Orthopedic Surgery; April 11, 1962, Surgery.

* * *

BLOOD SYMPOSIUM SET—The Tenth Annual Symposium on Blood will be held at Wayne State University, Detroit, January 19-20. The presentation of papers is scheduled to begin at 9 a.m., January 19. Facilities for a group dinner and social get-together are being reserved for that evening. The scientific session will be from 9 a.m. until 12 noon, January 20. The symposium will be held at the headquarters of the Wayne County Medical Society.

MEETINGS U.S.A.

November

American College of Chest Physicians, Interim Session, Brown-Pallace Hotel, Denver, Nov. 25-27. Mr. Murray Kornfeld, 112 E. Chestnut St., Chicago 11, Executive Director.

American Medical Association, Clinical Meeting Denver, Nov. 26-30. Dr. F. J. L. Blasingame, 535 N. Dearborn St., Chicago 10, Executive Vice-President.

American Society of Hemotology, Ambassador Hotel, Los Angeles, Nov. 27-29. Dr. John W. Rebuck, Henry Ford Hospital, Detroit 2, Secretary.

Conference on Graduate Medical Education, Nov. 30-Dec. 1. Dr. Paul Nemir, Jr., Dean, Graduate School of Medicine, University of Pennsylvania, Philadelphia 4.

National Conference on the Medical Aspects of Sports (Third), Cosmopolitan Hotel, Denver, Nov. 26. Fred V. Hein, Ph.D., Secretary, AMA Committee on the Medical Aspects of Sports, 535 N. Dearborn St., Chicago 10.

Radiological Society of North America, Inc., Palmer House, Chicago, Nov. 26-Dec. 1. Mr. Maurice D. Frazer, 3145 O Street, Lincoln, Neb., Secretary.

December

American Academy of Dermatology and Syphilology, Palmer House, Chicago, Dec. 2-7. Dr. Robert R. Kierland, Mayo Clinic, Rochester, Minn., Secretary-Treasurer.

1962

January

American Academy of Orthopaedic Surgeons, Palmer House, Chicago, Jan. 27-Feb. 1. Mr. John K. Hart, 29 East Madison St., Room 910, Chicago 2, Executive Secretary.

February

American Academy of Allergy, Denver-Hilton Hotel, Denver, Feb. 5-7. Mr. James O. Kelley, 756 North Milwaukee St., Milwaukee 2, Executive Secretary.

American Academy of Forensic Sciences, Drake Hotel, Chicago, Feb. 22-24. Dr. W. J. R. Camp, 1853 W. Polk St., Chicago 12, Secretary-Treasurer.

American Academy of Occupational Medicine, Pittsburgh, Pa., Feb. 7-9. Mr. William C. Stronach, 20 N. Wacker Dr., Chicago 6, Executive Director.

Central Surgical Association, Cincinnati, Feb. 22-24. Dr. Carl E. Lischer, 457 N. Kingshighway, St. Louis 8, Secretary.

Congress on Medical Education and Licensure, Palmer House, Chicago, Feb. 3-6. Dr. Walter S. Wiggins, 535 N. Dearborn St., Chicago 10, Director, AMA Council on Medical Education and Hospitals.

Society of University Surgeons, Cleveland, Feb. 8-10. Dr. C. Frederick Kittle, University of Kansas Medical Center, Kansas City 12.



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March

American College of Surgeons, Sectional Meeting, Sheraton-Cadillac Hotel, Detroit, March 5-7. Dr. William E. Adams, 40 E. Erie St., Chicago 11, Secretary.

April

Aerospace Medical Association, Atlantic City, April 9-12. Dr. William J. Kennard, Washington National Airport, Washington 1, D. C., Executive Vice-President.

American Academy of General Practice, Las Vegas, Nev., April 6-13. Mr. Mac F. Cahal, Volker Blvd., at Brookside, Kansas City 12, Mo., Executive Director.

American Academy of Neurology, Statler-Hilton Hotel, New York City, April 23-28. Mr. Thomas D. Swedien, 4307 E. 50th St., Minneapolis 17, Executive Secretary.

American Academy of Pediatrics, spring meeting, Statler-Hilton, New York City, April 30-May 2. Dr. E. H. Christopherson, 1801 Hinman Ave., Evanston, Ill., Executive Director.

American Association for Thoracic Surgery, Chase-Park Plaza Hotel, St. Louis, April 16-18. Dr. Henry T. Bahnson, Johns Hopkins Hospital, Baltimore 5, Secretary.

American College of Allergists, Hotel Radisson, Minneapolis, April 1-6. Dr. Maurice C. Barnes, 1310 Austin Ave., Waco, Texas.

American College of Obstetricians and Gynecologists, Palmer House, Chicago, April 2-5. Mr. Donald F. Richardson, 79 W. Monroe St., Chicago 3, Executive Secretary.

American College of Physicians, Bellevue-Stratford Hotel, Philadelphia 4, Executive Director.

American Proctologic Society, Deauville Hotel, Miami Beach, April 30-May 3. Dr. Norman D. Nigro, 7815 E. Jefferson Ave., Detroit 14, Secretary.

American Society of Internal Medicine, Benjamin Franklin Hotel, Philadelphia, April 6-8. Mr. G. Tod Bates, 350 Post St., San Francisco 8, Executive Director.

Industrial Medical Association, Pick-Congress Hotel, Chicago, April 10-12. Dr. Emmett B. Lamb, 23 East Ohio St., Indianapolis 4, Secretary.

SPEAKS IN DETROIT—Improving employe relations in Michigan hospitals was the theme of the third annual hospital personnel conference in Detroit, November 2-3. The conference, sponsored by the Michigan Hospital Association, was directed toward hospital board members, administrators, personnel officers and department heads. Speakers included Richard C. Bates, M.D., Lansing.

* * *

GIVES ADDRESS—Reed M. Nesbit, M.D., Ann Arbor, spoke about "Acute Renal Failure, a Rationale for Treatment and Prophylaxis" at the Detroit Branch of the American Urological Association, November 15, at the Wayne County Medical Society building.



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Michigan Authors

Melvin L. Selzer, M.D., Thomas Murphy, M.D., and Fariborz Amini, M.D., Ann Arbor, "Change of Supervisor and Psychotherapeutic Progress," *Archives of General Psychiatry*, August, 1961.

Albert E. Heustis, M.D., Lansing, "Local Health Services: How Do We Measure Up," *Canadian Journal of Public Health*, June, 1961.

Edmond L. Cooper, M.D., Detroit, "The Surgical Management of Secondary Exotropia," *Transactions, American Academy of Ophthalmology and Otolaryngology*, July-August, 1961.

A. D. Ruedemann, Jr., M.D., Detroit, and Werner K. Noell, M.D., Buffalo, New York, "The Electroretinogram in Central Retinal Degeneration," *Transactions, American Academy of Ophthalmology and Otolaryngology*, July-August, 1961.

Barbara Wiard Streeten, M.D., Ann Arbor, "The Sudanophilic Granules of the Human Retinal Pigment Epithelium," *Archives of Ophthalmology*, September, 1961.

Wilton A. Rightsel, Ph.D., Ruth A. Keltsch, B.S., and Alton R. Taylor, Ph.D., Detroit, Joseph D. Boggs, M.D., Chicago, and I. Wm. McLean, Jr., M.D., Detroit, "Status Report on Tissue-Culture Cultivated Hepatitis Virus. I. Vorology Laboratory Studies," *Journal, American Medical Association*, September 9, 1961.

Joseph D. Boggs, M.D., and Richard B. Capps, M.D., Chicago; Charles F. Weiss, M.D., Ann Arbor, and I. Wm. McClean, Jr., M.D., Detroit, "Status Report on Tissue-Culture Cultivated Hepatitis Virus. II. Clinical Trials," *Journal, American Medical Association*, September 9, 1961.

Frank N. Ritter, M.D., Ann Arbor, "A Clinical Study of Actinomycosis," *Archives of Otolaryngology*, September, 1961.

Delmar F. Weaver, M.D., Detroit, "Cancer of the Ethmoid Sinuses," *Archives of Otolarygology*, September, 1961.

Bruce Proctor, M.D., Detroit, "Tympanoplasty," *Archives of Otolaryngology*, September, 1961.

Carey P. McCord, M.D., Ann Arbor, "Man and His Environment, A Conference Résumé," *Industrial Medicine and Surgery*, September, 1961.

Thomas Francis, Jr., M.D., Ann Arbor, "Biological Aspects of Environment," *Industrial Medicine and Surgery*, September, 1961.

Roger P. Smith, Ph.D., and David M. Smith, M.D., Hanover, New Hampshire, and Detroit, "Acute Ipecac Poisoning," *The New England Journal of Medicine*, September 14, 1961.

W. Robert Day, M.D., Portland, Oregon, and Roy M. Goethe, M.D., Midland, "Chronic Meningococcemia in Infancy," *Northwest Medicine*, September, 1961.

Richard H. Mead, M.D., Book, "A History of Thoracic Surgery," Springfield, Illinois: Charles C Thomas, publisher.

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IN MEMORIAM

JOHN A. BELISLE, M.D., forty-seven, director of psychiatry at Wayne County General Hospital, died September 13, 1961.

Born in Detroit, Doctor Belisle was graduated from the University of Detroit in 1935 and from the Wayne State University College of Medicine in 1939. He interned at Receiving Hospital in Detroit and received his training in psychiatry at Wayne County General Hospital, Eloise. He served four years in the Army during World War II, returning to Eloise in 1945. At the same time, he joined the teaching staff of Wayne State University College of Medicine. He became director of psychiatry at Wayne County General in 1955.

He was certified by the American Board of Psychiatry and Neurology and was a member of the American Psychiatric Association.

CLIFFORD P. CLARK, M.D., seventy-five, retired Flint obstetrician, died August 27, 1961, at his home in Miami, Florida.

A graduate of Wayne State University College of Medicine, he was president of the Genesee County Medical Society in 1934. He retired from practice in Flint in 1951 and moved to Miami.

Doctor Clark was a Life Member of the Michigan State Medical Society and the Flint Academy of Surgery, and a member of the American College of Surgeons.

OTTO O. FISHER, M.D., eighty, retired Detroit physician and nationally-known collector of rare books and manuscripts, died September 15, 1961.

In addition to his collection of 20,000 books and manuscripts, he had wide interests in aviation and science. He was a past president of the Friends of the Detroit Public Library and a member of the board of publications at Wayne State University.

For many years prior to his retirement in 1945, Doctor Fisher was industrial surgeon for the Hudson Motor Car Company and was credited with establishing one of the first modern industrial first-aid units there.

A graduate of Johns Hopkins University, he served as an infantry major in World War I.

WILLIAM L. KEMP, M.D., sixty-five, Birmingham pediatrician since 1927, died September 12, 1961.

Dr. Kemp was head of the pediatrics department at William Beaumont Hospital, a staff member of Henry Ford Hospital, and attending pediatrician at Children's Hospital, Detroit.

A native of St. Clair, Doctor Kemp was a 1922 graduate of the University of Michigan and continued his medical studies there. He served his internship and residency at Henry Ford Hospital, followed by two years of postgraduate work as a resident at Research Educational Hospital, Chicago.

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He was a Diplomate of the American Academy of Pediatrics, and Trustee of the Detroit Pediatrics Society, the Child Research Center of Michigan, and Brookside, Kingswood and Cranbrook Schools. He had been a trustee of the Children's Fund of Michigan. In addition, he was a member of the Michigan Youth Commission, former member of the Michigan State Council of Health and had served as director of health for the city of Birmingham.

JACOB S. WENDEL, M.D., seventy-six, Detroit physician for forty-five years, died September 6, 1961.

Dr. Wendel was graduated from the University of Michigan Medical School in 1913. He was a Life Member of the Michigan State Medical Society and a past president of the Detroit Academy of Medicine and the Detroit Ear, Nose and Throat Society. He was also a member of the Detroit Athletic Club, Detroit Golf Club, and a founder and past president of the Harper Hospital Civil War Club, which was devoted to study and discussion of the war.

GEORGE W. WILLIAMSON, M.D., sixty-five, Dundee physician since 1934, died August 12, 1961.

Dr. Williamson was graduated from the University of Michigan Medical School and practiced in Deerfield, Michigan, before beginning practice in Dundee in 1934. He was a native of Brooklyn, New York.

In 1960, persons aged sixty-five and over constituted more than 9 per cent of the population compared with 4 per cent in that age group in 1910.

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Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

SYSTEM OF OPHTHALMOLOGY. Edited by Sir Stewart Duke-Elder. Vol. II. THE ANATOMY OF THE VISUAL SYSTEM. By Sir Stewart Duke-Elder, G.C.V.O., F.R.S., and Kenneth C. Wybar, B.Sc., M.D., Ch.M., F.R.C.S., Lecturer in Ophthalmology, University of London; Ophthalmic Surgeon, Moorfields Eye Hospital, and the Royal Marsden Hospital. 842 illus.; 3 colored plates. St. Louis: The C. V. Mosby Company, 1961. Price $30.00.

Sir Stewart Duke-Elder for many years has been a most profuse researcher and writer in all topics having to do with ophthalmology. He is now in the process of producing a 15-volume set. Volume II, The Anatomy of the Visual System, contains 900 pages of the most up-to-date and detailed information involving every possible part of the anatomy, reviewing in detail the history and all possible approaches to the minute microscopic anatomy of the eye and its ramifications. Duke-Elder has a style which is his own, easy reading, interesting, profuse with illustrations and examples. Every chapter is followed by an average of about a page of references. This book is an invaluable addition to any ophthalmological library and is completely up to date in every detail.

Books Received

GASTRIC CYTOLOGY. Principles, Methods and Results. By Rudolf Otto Karl Schade, M.D. (Dunelm), M.D. (Tuebingen), L.R.C.P., M.R.C.S., Senior Lecturer, Department of Pathology, Royal Victoria Infirmary, Kings College, University of Durham. London: Edward Arnold (Publishers) Ltd. Price, $8.00.

THE OLDER PATIENT. By twenty-one authors. Edited by Wingate M. Johnson, M.D., Chief of Staff, Private Diagnostic Clinic, and Professor Emeritus of Clinical Medicine, Bowman Gray School of Medicine of Wake Forest College. New York: Paul B. Hoeber, Inc., Medical Division of Harper & Brothers. Price, $14.50.

CONGENITAL MALFORMATIONS. Ciba Foundation Symposium. Editors for Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Cecilia M. O'Connor, B.Sc. 91 illus. Boston: Little, Brown and Company. Price, $9.00.

RESPIRATION PHYSIOLOGIC PRINCIPLES AND THEIR CLINICAL APPLICATIONS. By P. H. Rossier, A. A. Buhlmann, K. Wiesinger. Edited and translated from the German edition by Peter C. Luchsunger, M.D., Chief of Pulmonary Physiology Research Laboratory, Mt. Alto Veterans Administration Hospital, Washington, D. C.; Assistant Professor of Medicine, Georgetown University School of Medicine, Washington, D. C., and Kenneth M. Moser, M.D., Head of Chest and Contagious Disease Branch, U. S. Naval Hospital, National Naval Medical Center, Bethesda, Md.; Instructor in Medicine, Georgetown University School of Medicine, Washington, D. C. 95 illus. St. Louis: C. V. Mosby Company, 1960. Price, $15.75.

LIGHT COAGULATION. By Gerd Meyer-Schwickerath, M.D., Chief Municipal Eye Clinic, Essen, Professor of Ophthalmology, University of Bonn. Translated by Stephen M. Drance, M.B., F.R.C.S. (Eng.), Associate Professor of Ophthalmology, University of Saskatchewan, Saskatoon, Canada. 55 illus.; 7 in color. St. Louis: C. V. Mosby Company, 1960. Price, $9.00.

HEALTH PHYSICS INSTRUMENTATION. International Series of Monographs on Nuclear Energy. General Editors: R. A. Charpie and J. V. Dunworth. By John S. Handloser, Brookhaven National Laboratory, Upton, N. Y. New York-London-Oxford-Paris: Pergamon Press, 1959. Price, $6:50.

DRUGS OF CHOICE, 1960-1961. Editor: Walter Modell, M.D. Director, Clinical Pharmacology, and Associate Professor of Pharmacology, Cornell University Medical College; Attending Physician, New York Veterans Administration Hospital; Associate Visiting Physician, Bellevue Hospital; Member, Poison Control Advisory Board of New York City; Member, Revision Committee, United States Pharamacopeia XVI; Editor, Clinical Pharmacology and Therapeutics. St. Louis: C. V. Mosby Company. Price, $13.50.

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ANOREXIA NERVOSA. A Psychosomatic Medicine Monograph. Its History, Psychology, and Biology. By Eugene L. Bliss, M.D., Associate Professor of Psychiatry, University of Utah College of Medicine, and C. H. Hardin Branch, M.D., Professor and Head of Utah College of Medicine. New York: Paul B. Hoeber, Inc., Medical Division of Harper & Brothers. Price, $5.50.

VIRUS VIRULENCE AND PATHOGENICITY. Ciba Foundation Study Group No. 4, in honor of Prof. J. Mulder. Editors for the Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Cecilia M. O'Connor, B.Sc. 13 illus. Boston: Little, Brown and Company.

THORACIC SURGERY BEFORE THE 20TH CENTURY. By Lew A. Hochberg, B.S., M.A., M.D., C.M., F.A.C.S., F.C.C.P., and F.A.C.C., Consultant Thoracic Surgeon, Lutheran and Sea View Hospitals; Visiting Thoracic Surgeon, Coney Island Hospital; Attending Thoracic Surgeon, Adelphi, Beth-El, Brooklyn Hebrew Home, Jewish Chronic Disease and Unity Hospitals; Associate Surgeon, Caledonian and Prospect Heights Hospitals. New York-Washington-Hollywood: Vantage Press. Price, $15.00.

THE CONCISE ENCYCLOPEDIA OF MODERN SURGERY. By James Hale Rutledge, B.S., M.D., F.A.C.S. Illustrated by the author. Philadelphia and New York: Chilton Company—Book Division, 1961. Price, $8.00.

COMMUNICATIONS

John M. Dorsey, M.D.
Wayne State University
Detroit, Michigan

Dear Dr. Dorsey:

I have just received in Hollidaysburg, Pennsylvania, where I am on vacation, your pamphlet "Narcotics Addiction in Our Community Primarily an Educational Problem." This is indeed a milestone in the solution of this problem and should be the guidepost for local effort, with the aid of State and Federal units. We shall appreciate your sending us about twenty copies of this pamphlet.

I am suggesting to the Director of the United Nations Division of Narcotic Drugs that this be inserted in the *United Nations Bulletin on Narcotics* for the enlightenment of local forces in the world where a problem exists.

I hope that you will locate a suitable hospital facility soon so that the project can get under way.

Thanks for your diligent and forceful attention to our mutual problem.

Sincerely yours,
H. J. Anslinger
Commissioner of Narcotics
U. S. Bureau of Narcotics

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Editorial Comment

A Fable

Rocky Mountain Medical Journal, April, 1960

A small private hospital of 100 beds ran efficiently with an administrative staff of one administrator, one business manager, and five secretaries. The house staff consisted of three residents and six interns who were paid by the hospital. They were taught by the staff doctors who were in private practice and received no pay. This hospital was filled with patients who received excellent care. There was no waiting list, and the people in the community were happy and healthy.

Then this fine hospital was taken over by the state. First came the administrator with his two assistants and each had two secretaries. Since there was not enough office space, five patient rooms were converted into offices. Next arrived the business manager with his two assistants and their six secretaries and with them went ten more hospital beds. The efficiency expert arrived with an assistant and three secretaries, which used up five more rooms. The professional staff expanded to 12 full time chiefs, each with a full time assistant and each one with at least one secretary. The house staff went from nine to 55. Each department needed a research laboratory, so more beds were appropriated. When the reorganization was over, the hospital, which had been operating on a budget of $300,000 a year—paid by the patients, was costing three and a half million a year—paid by the taxpayers. This, of course, did not include the $300,000 received in federal grants for research of questionable necessity and merit—also paid by the taxpayer.

At this time it was discovered that the need for office space had left only one bed for patients. Immediately each department claimed the single bed. As a result, the only patient in the place alternated between complete neglect, examination, and treatment by the whole staff. The strain of 50 physical examinations a day, supplemented by millions of laboratory tests, conflicting, cancelled, and reordered orders, along with infusions, transfusions, enemas, lavage, gavage, etc., brought on his early demise. Autopsy revealed death was caused by exhaustion, acute therapeutic anemia, and a perforated stress ulcer.

With the death of the single patient, the last remaining bed was converted into a conference room. Here the staff met and after months of deliberation, came up with a brilliant solution—they sent a request to the state legislature for ten million dollars to build a new 100-bed hospital.

Doctors Become Sponsors

Flint Journal, September 16, 1961

An unusual and most heartening contribution to Flint's College and Cultural Development has been made by more than 100 Genesee County medical doctors. Their combined donations provided a $107,000 sponsorship.

The substantial financial contribution is an important boost in furthering the campaign by the Development's Committee of Sponsors to meet its stated goals of additional buildings and expanded facilities.

The sponsorship represents more than that, however. The group's endorsement of the Development and expressed interest in Flint's educational and cultural opportunities serves to re-emphasize the community consciousness and outstanding service of individual doctors and the Genesee County Medical Society.

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THE COVER

The December MSMS Journal salutes the Calhoun County Medical Society. The cover shows the four ristoric hospitals and the three modern institutions which serve Battle Creek. See also page 1558 for more information.

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DELEGATES TO A. M. A.

Delegates

	Term Expires
J. S. DeTar, M.D., Milan	1961
W. A. Hyland, M.D., Grand Rapids, *Chairman*	1961
O. J. Johnson, M.D., Bay City	1961
C. I. Owen, M.D., Detroit	1961
Wm. Bromme, M.D., Detroit	1962
R. L. Novy, M.D., Detroit	1962
G. W. Slagle, M.D., Battle Creek	1962

Alternates

	Term Expires
W. W. Babcock, M.D., Detroit	1961
G. B. Saltonstall, M.D., Charlevoix	1961
J. M. Wellman, M.D., Lansing	1961
B. M. Harris, M.D., Ypsilanti	1961
L. R. Leader, M.D., Detroit	1962
J. R. Heidenreich, M.D., Daggett	1962
D. N. Sweeny, Jr., M.D., Detroit	1962

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President's Page

THAT ALL-IMPORTANT FOURTH AREA



President
Michigan State Medical Society

As doctors of medicine, we often hear speakers discuss three major areas of Medicine—Research, Teaching and Practice.

We heartily agree that these three areas of activity are important to the general public and to each of us. The practitioner could not perform without the research and teaching support; teaching would be meaningless unless there were practitioners to carry out the work, and research would be fruitless if the teaching and practice arms did not utilize new knowledge and information.

But, I would like to direct our thoughts for a minute to the fourth area—The Maintenance of a Proper Environment for Medicine.

Whether the individual doctor is in research, teaching or in everyday practice, he has a personal concern about an environment that is conducive to progress. As one long active in medical organizations, I suggest that this is the prime responsibility of the county medical societies, the state medical society, and the American Medical Association; their main service is to protect and improve the necessary professional environment.

The environment that we need cannot be gained and maintained by any one group of doctors. The man in practice cannot do it alone—nor can those in research or teaching. Together, the three can—and must—evaluate from time to time the type of environment they need to provide for the best medical care for the most people; then, working together, see to it that that condition evolves.

We begin to contribute when we attend county society meetings, when we participate in the excellent Michigan State Medical Society meetings, and when we join men from other states at the AMA meetings. We contribute more fully as we assume responsibilities as officers and members of county, state and national committees. Work within our specialty groups and with lay organizations in the health field is necessary, too, to augment the positive programs of these basic organizations.

My concern about the environment we need can be likened to the effects of soils, moisture, temperature, sunshine, et cetera, upon the growth and fertility of a tree. The roots represent research, the trunk and branches represent teaching, and the flowers and fruit represent the practice of medicine and related benefits to mankind. This tree cannot be strong and really productive, unless the environment is right. Through your help the tree of medicine can grow stronger and produce more fruit. We need the special knowledge of each one of you if your society is to work effectively for the right kind of environment for your research, your teaching or your practice.

County Secretaries—PR Seminar Set February 3



One of the highlights of the annual MSMS County Secretaries Public Relations Seminar, Saturday, February 3, 1962, will be an address by a Texas communications expert.

The Seminar participants will hear Professor William DeMougeot, of North Texas State University. He was the headliner at the 1961 AMA Institute in Chicago and was immediately contacted for the MSMS Seminar.

Once again, the County Secretaries-Public Relations Seminar will be conducted for every county society President, President-Elect, Secretary, Editor, and Executive Secretary; and also for members of the MSMS Council, and for the MSMS Public Relations Committee members and Legal Affairs Committee members. Also invited are representatives of the Woman's Auxiliary to MSMS and the Michigan State Medical Assistants Society.

This year, the Seminar will be held at Kellogg Center on the Michigan State University campus.

Nationally known as a debating authority, educator and researcher, Professor DeMougeot will come from Denton, Texas, for the MSMS program.

In his address at Chicago, Professor DeMougeot challenged Medicine to take a more positive approach by demanding that the supporters of socialized medicine show the alleged drastic need for such a program. He contended, "I want you doctors to win your fight against socialized medicine because I think we can solve the problems that still exist in paying for medical care without going to the extremes that less-wealthy nations felt they had to adopt. We must use all the arguments that have logical validity."

* * *

County Societies Given Aid With Speakers Bureaus

Representatives of county medical societies joined officials of MSMS for a one-day "Speakers Training Session" held at the new MSMS headquarters building in October.

The workshop started fast with a challenging address by MSMS President Otto K. Engelke, who outlined the positive program of Medicine. Darrell Coover, director of the AMA Speakers Bureau, followed with specific guidance for the county medical society on how to organize and utilize a county speakers bureau. Members of the MSMS staff discussed resource materials available from the state society. Visual aids were stressed by a Michigan State University expert.

Classroom instruction followed with three smaller sessions to cover

such topics as speech planning, speech presentation, radio and television, and other topics.

Following are some of the highlights of the address by Mr. Coover:

"THE DESTINY OF Michigan medicine will not be decided by the MSMS. This decision will be made by the highest court of all—public opinion. The MSMS through you—the doctor of medicine and your local association—can exert an influence capable of directing the decision in favor of medicine and beneficial to the public.

"Just as Harry Truman in 1948, we find ourselves with unfavorable press, condemned by at least a portion of Congress and regarded questionably by the general public. We must now take our story directly and personally to the people as did Harry Truman. If we do this with sincerity and simplicity, the results shall be the same for medicine tomorrow as they were for him in 1948. The 'whistle-stops' must include women's clubs, lodges, service clubs, PTA's, church groups . . . anywhere people gather and will listen to a speaker. We must begin now, for this 'election' takes place every day in the minds of the public as they are now constantly exposed to evidence of all kinds.

"The device to be used for this method of campaigning is the Speaker's Bureau. Your local association can form one very simply:

"First, check your membership for every person who can stand before a group of people and talk sincerely about medicine. They do not have to be orators but they must, above all, be sincere.

"Second, notify all the clubs in your area that you have programs and speakers on medicine available. You may do this by letter, newspaper ads, and by word of mouth. Every doctor or a part of his family is a member of such a group. Have each of them arrange for a program at one of their meetings. These groups are constantly in search for programs and are more than happy to have one on medicine. We are controversial at the present time, and you will have no trouble finding interested listeners.

"The most effective way to train persons who have no experience in public speaking is to use one experienced speaker for the main presentation with a panel of two or three 'neophytes' to answer the questions that follow. This gives them experience and overcomes their stage fright. With a little such seasoning, they are ready to go out on their own, taking other 'neophytes' along for seasoning. Your core of speakers will grow quickly.

"The P-R Chairman of each county should be authorized by the officers to begin this activity at once by selecting the members who can now effectively present the story of medicine. Then line up your second team composed of 'trainees' to supplement the main speakers. Send out letters over your president's signature to the program chairman or president of all available groups. Notify all your members of the availability of your Speaker's Bureau and enlist their aid in obtaining bookings.

"Publicize the work by making sure the newspapers receive a notice of the meeting, who spoke, and the subject. You can get the publicity chairman of the host organization to help with this as it means publicity for them as well.

"Once a few such talks have been given, and given well, you will find people calling and asking for speakers.

"Material for these programs is readily available from the MSMS office. There is literature available to distribute to your audience."

ATTENDANCE AT Speaker's Training Session:

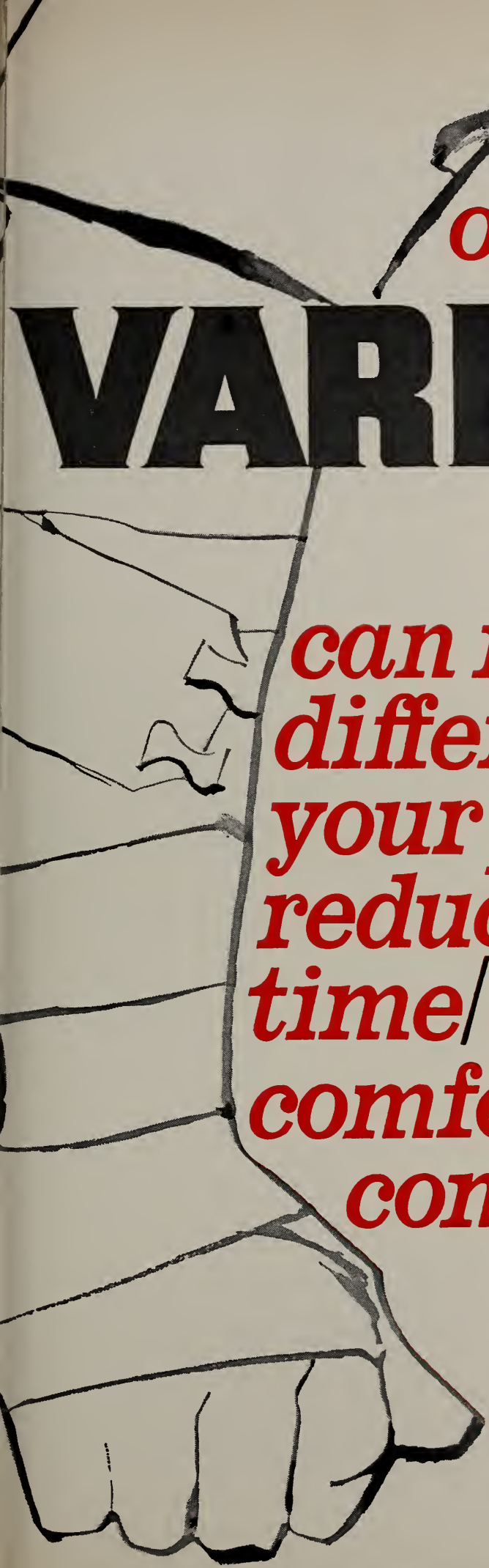
V. V. Bass, M.D., Saginaw; H. G. Benjamin, M.D., Grand Rapids; J. W. Bunting, M.D., Alpena; H. T. Caumartin, M.D., Saginaw; Wm. J. Dinnen, M.D., Port Huron; L. A. Drolett, M.D., Lansing; Otto K. Engelke, M.D., Ann Arbor; K. E. Fellows, M.D., Grand Rapids; L. E. Grate, M.D., Charlevoix; C. M. Hanson, M.D., Kalamazoo; N. D. Henderson, M.D., East Lansing;

E. H. Heneveld, M.D., Muskegon; D. B. Hiscoe, M.D., Lansing; Stanley L. Hoffman, M.D., Howell; Jack Hoogerhyde, M.D., Grand Rapids; Kenneth H. Johnson, M.D., Lansing; J. L. Leach, M.D., Flint; E. L. Long, M.D., Detroit; W. Kaye Locklin, M.D., Kalamazoo; H. E. Malcolm, M.D., East Lansing; Oliver B. McGillicuddy, M.D., Lansing; D. W. McLean, M.D., Detroit;

Louis E. May, M.D., Howell; H. P. Muldoon, M.D., Grand Rapids; P. T. Mulligan, M.D., Mt. Clemens; Clarence I. Owen, M.D., Detroit; J. C. Rawling, M.D., Flint; R. W. Teed, M.D., Ann Arbor; H. A. Towsley, M.D., Ann Arbor; Bernard C. Wildgen, M.D., Muskegon; D. Bruce Wiley, M.D., Utica.

MICHIGAN MEDICAL MEETINGS AND CLINIC DAYS

January 19-20	Symposium on Blood	Wayne County Medical Society, Detroit
January 25-26	Michigan Society of Gerontology	Occidental Hotel, Muskegon
February 3	MSMS County Secretaries-Public Relations Seminar	Kellogg Center East Lansing
February 9-10	Congress of the Professions	Kellogg Center, East Lansing
February 10	Michigan Heart Day	Statler Hotel, Detroit
February 15-16	Conference on Hospital Patient Safety	Ann Arbor
February 28, March 1-2	Michigan Clinical Institute	Detroit
March 5-6-7	American College of Surgeons Sectional Meeting	Sheraton-Cadillac Hotel, Detroit



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HIGHLIGHTS of the Council

Meetings of September 24 and 28, 1961

Ninety-seven items were presented to The Council at its two meetings held co-incident with the MSMS Annual Session in Grand Rapids. Chief in importance were:

- Financial report to August 31 was presented by Finance Committee Chairman Oliver B. McGillicuddy, M.D., of Lansing. Included was the cost of new MSMS exhibit at Michigan State Fair—which won first prize in its class. A vote of thanks was extended to all physicians and other volunteers who manned the exhibit during the ten hot, humid days of the Fair.
- MSMS statement of policy re use of hospitals by allied health professional personnel, based on AMA Resolution No. 50 (of June 1961, New York session) was adopted. This statement is printed on page 1498.
- Plans for the Annual Session of The Council to be held in East Lansing, February 1-2, 1962, as well as proposed program for County Secretaries-Public Relations Seminar, scheduled for East Lansing February 3, were reviewed and approved. The program for the workshop of Michigan's County Society Executive Secretaries, to be held at MSMS Headquarters November 9, was approved.
- The publishing of a digest of the Annual Report of The Council, to be known as the "Annual Report of the Michigan State Medical Society," was authorized.
- President K. H. Johnson, M.D., of Lansing presented a progress report of the new MSMS building and its maintenance; on the appointment of a new AMA Field Secretary to cover the State of Michigan—William R. Ramsey, formerly of King County Medical Society, Seattle, Washington; preliminary plans for installing first aid medical facilities in the Lansing Civic Center for Delegates to the Michigan Constitutional Convention, which plans were approved by The Council.
- Carleton Fox, D.D.S., of Detroit presented to the MSMS President a gavel made from the timber of the original Beaumont House on Mackinac Island "as a reminder of the great contribution made by Doctor Beaumont in 1820 in the most primitive surroundings." Wm. M. LeFevre, M.D., of Muskegon supplied a hand-made box container for the gavel. Both Doctors Fox and LeFevre were thanked for this contribution to The Society, the gavel to be known as "The Presidents Gavel."
- Letter from the National Foundation, re patient-aid policies not permitting payment of professional fees, was received as information and was ordered published in THE JOURNAL and in The Secretary's Letter.
- Testimony before House Ways and Means Committee in Washington re King-Anderson Bill. Otto K. Engelke, M.D., MSMS President-Elect, complimented the MSMS staff, officers and AMA staff in Washington for help in making his appearance in Washington an effective one. He especially praised MSMS efforts in obtaining extensive and favorable local publicity for the MSMS testimony.
- Resignation of Council Vice-Chairman T. P. Wickliffe, M.D. Doctor Wickliffe stated he wished to announce his resignation as Councilor of the Thirteenth District as he planned to move to California November 1. Doctor Wickliffe's action was received with sincere regret and with thanks for his notable contributions to the Michigan State Medical Society and to the medical profession of Michigan.
- G. Thomas McKean, M.D., President, and Mr. Sumner Whittier, Executive Vice-President, reported on matters pertaining to Michigan Medical Service and to Medicare.
- The Supplemental Annual Report of The Council was reviewed, amended, and approved for presentation to The House of Delegates.
- At the second meeting of The Council (September 28) the newly elected Officers and Councilors were introduced: C. I. Owen, M.D., of Detroit, President-Elect; W. C. Carpenter, M.D., Detroit, Councilor of First District; E. E. Martmer, M.D., Detroit, Councilor of First District; H. C. Hansen, M.D., Battle Creek, Councilor of Third District; Wm. A. Scott, M.D., Kalamazoo, Councilor of Fourth District; C. Allen Payne, M.D., Grand Rapids, Councilor of Fifth District; H. H. Hiscock, M.D., Flint, Councilor of Sixth District; D. R. Smith, M.D., Iron Mountain, Councilor of Thirteenth District.
- Reorganization of The Council:
 1. O. B. McGillicuddy, M.D., of Lansing was chosen as Chairman of The Council.
 2. O. J. Johnson, M.D., of Bay City was selected as Vice-Chairman of The Council.
 3. Robert J. Mason, M.D., of Birmingham was elected as Chairman of the County Societies Committee.
 4. W. W. Babcock, M.D., Detroit, was made Chairman of the Finance Committee.

5. Wm. A. Scott, M.D., Kalamazoo, was selected as Chairman of the Publication Committee.

- The Public Relations Counsel's monthly report included: (a) progress on pilot-survey of medical aid to the aged by the Ingham County Medical Society for information on the workings of MMA program in Michigan. A number of detailed questions will be asked of the Ingham County Bureau of Social Aid and an effort will be made to receive regular monthly statistics regarding the program, all information available to MSMS. If successful, the program is to be recommended to a number of other representative counties in Michigan with a view to improving implementation of the program by M.D.'s generally. (b) An MSMS Membership Services Exhibit has been developed and was shown for the first time at the Annual Session in Grand Rapids. (c) An excellent response to the poster-pamphlet card offer, an easel display for the doctor's office, has been received. (d) A training session for speakers is scheduled at MSMS headquarters for October 19.
- The Council placed on its minutes a vote of thanks to Parke, Davis and Company for exhibiting "The History of Medicine" at the 1961 Annual Session; the firm was complimented for continuing an excellent public relations program to both doctors of medicine and lay groups throughout the country.
- Executive Director Wm. J. Burns was authorized to attend the Second Michigan Consumers Protective Conference to be held at Cobo Hall, Detroit, November 2 as a member of the panel on "Quackery and Nostrums in the Health Field."
- Legal Counsel's report included:
 (a) opinion on whether a person may leave his body to a medical school or hospital for scientific purposes;
 (b) review of newspaper story concerning death of a prisoner in county jail under circumstances which cast some unfair reflections on the medical profession;
 (c) opinion with respect to various complicated legal questions arising out of relations between a county medical society and welfare authorities;
 (d) opinion on legality of intravenous medication by nurses;
 (e) Legal Counsel was authorized to render an opinion in connection with a possible student survey, in a Michigan University, on the clinical response of students suffering from colds to a new drug being developed by a pharmaceutical house.
- The following committee reports were reviewed: (a) 1962 MCI Committee on Arrangements, meeting of July 19, and of its Program Committee, meeting of August 30, (b) Courses on Medical Economics and Ethics, August 20, 1961, (c) Committee on Insurance, August 22, 1961, (d) Scientific Radio Committee, August 23, (e) Disaster Medical Care Committee, September 13, (f) Healing Arts Study Committee, September 13 (which included recommendation to the House of Delegates that a joint committee, of The House of Delegates and The Council, be appointed to give study to the osteopathic question as it applies to Michigan), (g) Mental Health Committee, September 14, (h) Publication Committee of The Council, September 24, (i) Medical Care Study Committee, July 13, (j) Legal Affairs Committee, July 14, and its sub-committee on single medical practice act, April 27, (k) Liaison Committee with State Bar of Michigan, June 14, which included "Principles Governing Hospitals, Lawyers and Doctors," with respect to hospital records and contacts between lawyers and patients, which were accepted by The Council as modified by the Committee.
- Matters of mutual interest were discussed with Michigan State Health Commissioner A. E. Heustis, M.D., including (a) departmental activities, (b) flu vaccine, (c) poliomyelitis, (d) radioactive fall-out, (e) legislation, (f) budget requests.
- President-Elect C. I. Owen, M.D., was appointed a member of the Centennial Committee for the 1965 MSMS Annual Session in Detroit.
- Representatives appointed:
 1. C. P. Anderson, M.D., Detroit, to attend Twelfth County Medical Society Conference on Disaster Medical Care, in Chicago, November 4-5, 1961.
 2. Public Relations Counsel H. W. Brenneman to attend Public Relations Society of American Annual Meeting in Houston, November 13-16, 1961.
 3. George W. Slagle, M.D., Battle Creek, to attend AMA National Congress on Prepaid Health Insurance, Chicago, October 14-15, 1961.
 4. G. E. Millard, M.D., Detroit, and J. W. Rice, M.D., Jackson, to attend American Association of Medical Assistants, Reno, October 13-15, 1961.
 5. President Otto K. Engelke, M.D., Ann Arbor, to attend American Medical Association Clinical Meeting, Denver, November 27-30, 1961.
- Reports: The report of R. W. Teed, M.D., Ann Arbor, on American Medical Association Institute held in Chicago, August 31-September 1, was accepted, with thanks; The report of G. E. Millard, M.D., Detroit, on Michigan Association of the Professions Conference with School Counselors, Alma College, July 8-9, was accepted with thanks;

the report of A. Jackson Day, M.D., Detroit, on AMA Workshop re Relative Value Study, held in Kansas City, September 16, was accepted with thanks.

- A Fifty-Year Award was presented posthumously to Harry A. Barbour, M.D., who had practiced in Flint for fifty years prior to his death in 1954.
- A special vote of thanks was extended to B. M. Harris, M.D., of Ypsilanti, Wm. M. LeFevre, M.D., Muskegon, and Oliver B. McGillicuddy, M.D., of Lansing for valuable services as Chairman of the Council's Standing Committees for many years.
- Official recognition and thanks to retiring Councilors and Officers for contributions to the Michigan State Medical Society over the years was authorized by The Council, which also placed on its minutes a special vote of thanks to all who helped make the 1961 MSMS Annual Session an outstanding success, particularly H. G. Benjamin, M.D., Grand Rapids, General Chairman; David Kahn, M.D., Lansing, Chairman of the Program Committee, and J. R. Lentini, M.D., of Grand Rapids, Chairman of the Committee on Scientific Exhibits.
- An informational briefing session for new Councilors was authorized by The Council, to be held November 15, 1961, in East Lansing.

A Psychiatrist Looks at the MSMS Presidents Plan

In this paper, my views will be summarized under three categories.

1. *It is not enough to add years; we must add good ones.* This implies not only an orthodox approach to the purely physical problems of the oldster, but also suggests research into the psychologic, the sociologic, and the economic status of the oldster.

(a) Preservation of the capacity of the oldster to master his environment needs to be understood so that his feelings of usefulness can continue.

(b) Changes in the patterns of hospitalization of older people must be diligently understood. Great, impersonal hospitals must yield to smaller, community oriented, institutions which aim to keep the oldster out of institutional living, rather than in it. Hospitals which are devoted to the understanding of the psychic problems of these people can supercede those in which expensive, often unnecessary, somatic care is the chief interest.

(c) Particularly in large population centers, the physician must be interested in housing patterns which will tend away from the impersonal characteristics of most big city dwellings.

2. *It is well within our present knowledge to accomplish part of the things listed above.* Experiments in several different localities have indicated patterns which can be followed and elaborated. In addition, changes in housing laws by the Federal Government have made possible the development of much more useful and adequate dwellings for older people.

3. *What we already know and what we can already do represents only the barest beginning.* Most of the information which we now have about geriatrics and even gerontology represents the reasoning of interested and often very capable people about what ought to be the problem. This is emphatically insufficient. In no other branch of medicine is there such absence of empirical proof of theses. Adequate studies even of the question of retirement being beneficial or the opposite do not exist.

It is for this reason in particular that medicine is uniquely qualified to take the lead, wresting it from politicians and do-gooders. If the established course of medical research is followed, it can lead the population out of the morass of conflicting ideologies and short-sighted, impractical panaceas.

(a) A program within the state can be established with the cooperation of the medical schools and the state medical society. This should be a multidisciplinary endeavor under the proper direction of medical authority.

(b) The program should be developed and divided into two distinct phases, which can be worked on concomitantly.

(1) A basic research, primarily and almost solely under the auspices of the medical schools, is essential. So little is known about the genesis or treatment of a tremendous group of degenerative disorders that more talent and money and time could very well be devoted to their investigation. The same is true of a vast group of metabolic disorders.

(2) A clinical research program which, it is to be hoped, would enlist the active cooperation of every physician in the state, should be a joint venture of the medical society and the medical schools.

A. H. Hirschfeld, M.D.

MSMS Chairman Cited

Charles P. Anderson, M.D., Detroit, chairman of the MSMS Committee on Disaster Medical Care, was honored recently for his contributions to medical-health and disaster preparedness. Dr. Anderson was presented the Pfizer Award of Merit at the 10th Annual Conference of the U. S. Civil Defense Council in Los Angeles. Dr. Anderson was cited for his "organizational activity in civil defense and disaster, chemical, radiological and biological non-military defense and mass casualty care." He is deputy director of medical service for Detroit Civil Defense.

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Meet the New MSMS Councilors

Short biographic sketches of the new MSMS Councilors, elected at the 1961 Annual Session, appear below.

WILLIAM S. CARPENTER, M.D., Detroit



William S. Carpenter graduated from Northwestern University Medical School in 1936 and interned at Harper Hospital from 1936 to 1938. He was a resident in Surgery at Receiving Hospital from 1938 to 1941. From 1941 to 1946, he served in the United States Army Medical Corps.

He is a Diplomate of the American Board of Surgery, a Fellow of the American College of Surgeons, and is on the active staffs of Harper, Mount Carmel, Mercy, and Sinai Hospitals. He is Senior Instructor at Wayne University Medical School. He was a Director of Michigan Medical Service from 1958 to 1960, and has been a Delegate from Wayne County Medical Society for many years.

HARVEY C. HANSEN, M.D., Battle Creek



Harvey C. Hansen was born and raised in Battle Creek, and attended the University of Nebraska. He received his medical degree from the University of Michigan in 1927, doing his internship and resident work at University Hospital in Ann Arbor.

Dr. Hansen served in the United States Air Force for five years and two months, in Regional Hospital in Orthopedic Surgery. He was discharged in 1946 as a Lieutenant Colonel in the Medical Corps.

He served as a Delegate to the Michigan State Medical Society from 1936 to 1961, except for periods in military service. He is one of the five physicians in Battle Creek who did the basic work on the original Blue Shield program.

His practice is limited to orthopedic and industrial surgery. He is Attending Orthopedic Surgeon at Community Hospital, Leila Hospital and the Battle Creek Health Center, and Orthopedic Consultant to the Veterans Administration Hospital.

EDGAR E. MARTMER, M.D., Grosse Pointe



Edgar E. Martmer, born in 1901, received his M.D. degree from Wayne University in 1926. From 1927 until 1934, he was associate epidemiologist at the Detroit Department of Health. He was certified by the American Board of Pediatrics in 1934. He has been in private practice in Detroit from 1927 until the present time. He saw service in World War I from 1917-18, and also in World War II from 1942-1945.

He is Past President of the Detroit Pediatric Society, Past Chairman of the Pediatric Section of the Michigan State Medical Society and Past President of the American Academy of Pediatrics, Michigan Branch.

Since 1930, he has been an Associate Professor of Clinical Pediatrics at Wayne College of Medicine, and was the first recipient of the Clifford G. Grulee Award of the American Academy of Pediatrics. He is Chief of the Department of Pediatrics, Harper Hospital.

D. ROEMER SMITH, M.D., Iron Mountain



D. Roemer Smith, M.D., is a graduate of the State University of Iowa, receiving his medical degree in 1925. He is a member of the Dickinson County Medical Society, the Michigan State Medical Society and the American Medical Association. He is a Fellow of the American College of Surgeons and a member of the Board of Trustees of Michigan Hospital Service. He is Chief of Staff of Dickinson Memorial Hospital and a member of the House of Delegates of the Michigan State Medical Society.

New from Saunders

1 Graham, Sotto and Paloucek—Cancer of the Cervix

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This authoritative new monograph, from the world-famous *Roswell Park Memorial Institute*, brings you today's latest information on the diagnosis and management of cervical cancer. The authors begin with an interesting discussion of the frequency, etiology and pathology of such lesions. There are extensive sections on diagnosis and therapy — including complications affecting management such as *pregnancy, prolapse of the uterus, carcinoma of a cervical stump, and fever.* You'll find fully illustrated coverage of techniques of obtaining material for Papanicolaou smears and performing cervical biopsy. Both irradiation and operative techniques are explained and illustrated in detail.

By John B. Graham, M.D., Chief Gynecologist; Luciano S. J. Sotto, M.D., formerly Attending Gynecologist; and Frank P. Paloucek, M.D., Attending Gynecologist. All of the Roswell Park Memorial Institute, Buffalo, New York. About 544 pages, 6½"x9¾", with 157 illustrations. About $15.00. *New—Ready in January!*

2 Hogan and Zimmerman—Ophthalmic Pathology

New (2nd) Edition!--A superb atlas and textbook on the eye and its disorders

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Edited by Michael J. Hogan, M.D., Professor and Chairman, Department of Ophthalmology, University of California School of Medicine, San Francisco; and Lorenz E. Zimmerman, M.D., Chief, Ophthalmic Pathology Branch and Registrar, Registry of Ophthalmic Pathology, Armed Forces Institute of Pathology, Washington, D.C.; with 15 Contributors. 797 pages, 7½"x11", with 703 figures, some in color. About $30.00. *New (2nd) Edition!*

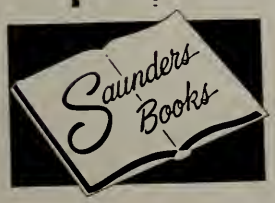
3 Owen—Hospital Administration

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Edited by Joseph Karlton Owen, B.S., M.S., Ph.D., Specialist in Hospital Administration, Louis Block and Associates, Inc., Silver Spring, Md.; with the Coordinative Assistance of Robert K. Eisleben, B.A., M.A., Assistant Administrator of Little Company of Mary Hospital, Torrance, Calif. About 960 pages, 6½"x9¾", with 186 illustrations. About $16.00. *New—Ready in January!*

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Statement of Policy Re Allied Health Professions and Services in Hospitals

On September 24, The MSMS Council approved the following resolution:

Whereas, MSMS has from time to time received requests from various members for a statement of policy as to the relationship of medicine with allied health professions and services, such as chiropody, et cetera, and

Whereas, the need for and beneficial use in hospitals of the talents of members of the allied health professions and services is well accepted, and

Whereas, the extent of independent privileges to be granted in hospitals to members of allied health professions and services is a matter of great legal and professional concern, and

Whereas, experience and public safety considerations require that the medical staff of a hospital be organized and responsible to the governing board of the hospital and the public for the competence and quality of professional and medical care, and

Whereas, granting of privileges to a qualified podiatrist will not cause a hospital to be penalized by the Joint Commission on Accreditation, and

Whereas, one of the Joint Commission on Accreditation's requirements is that a hospital be accepted for listing by the American Hospital Association, and

Whereas, the American Hospital Association states that only Doctors of Medicine or doctors of osteopathy shall practice in hospitals listed by the American Hospital Association, and patients admitted for services other than by doctors so mentioned must have history and physical examination done by a physician on the staff of the hospital and a physician on the staff of the hospital shall be responsible for the patient's medical care throughout his stay, and

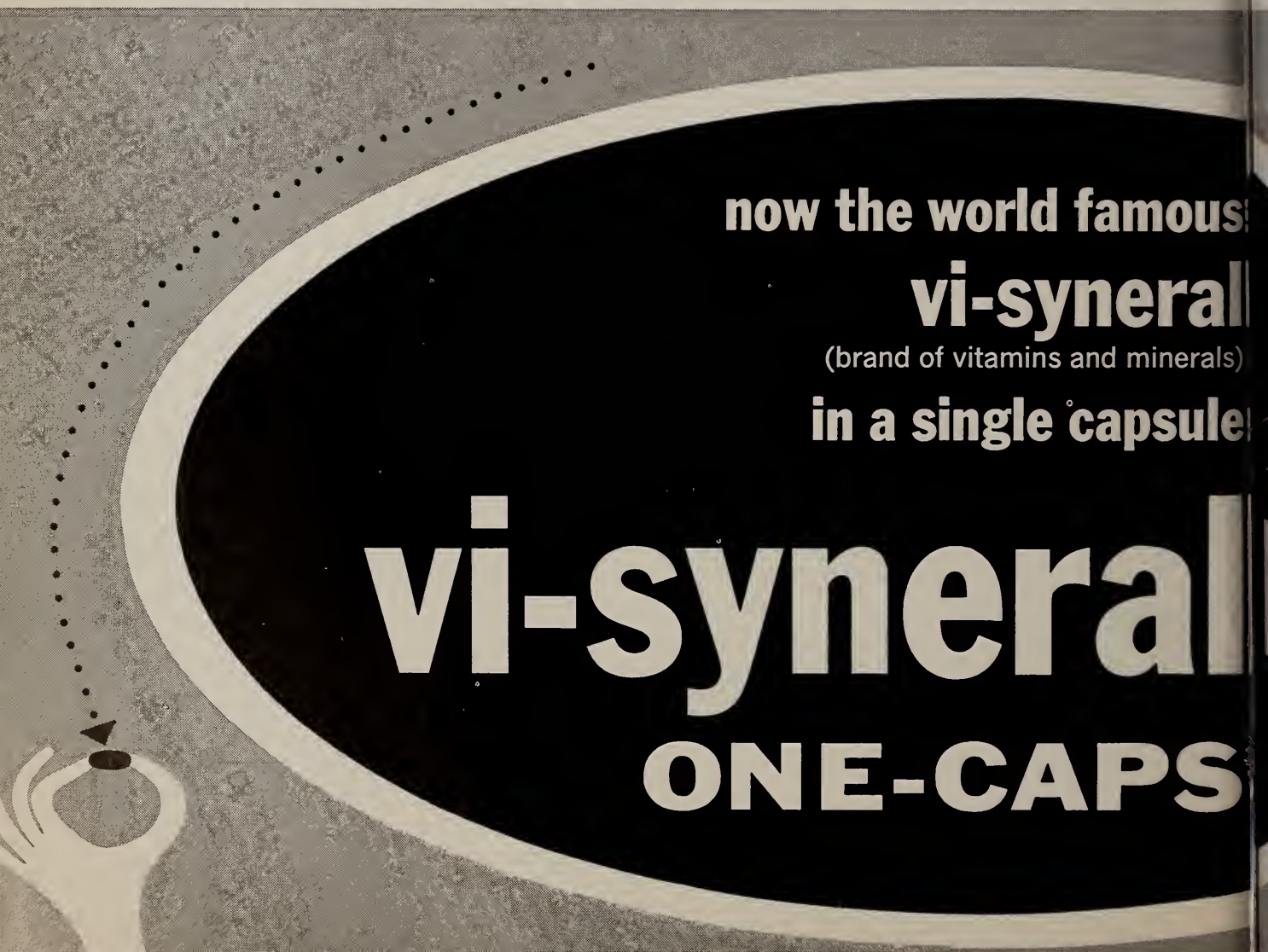
Whereas, the extent of professional medical services available and rendered varies at the local level with the size, type and staff organizations of the hospitals and community served, and

Whereas, the best interests of the public, hospitals, the medical profession and allied health professions and services will be better promoted by the formulation and adoption of appropriate guiding principles, therefore be it

RESOLVED: That the following statements of policy and principles be endorsed—

1. Hospital staff privileges should be limited to competent and qualified physicians and surgeons and all patients will be admitted to hospitals by them only.

2. The services of certain allied health professions and services which are necessary and proper to hospital function and treatments therein may be available within the limits of their technical skills, and the scope of their lawful practice, under the direction and supervision of a physician or surgeon member of the medical staff of the hospital, who is appropriately qualified in that field.



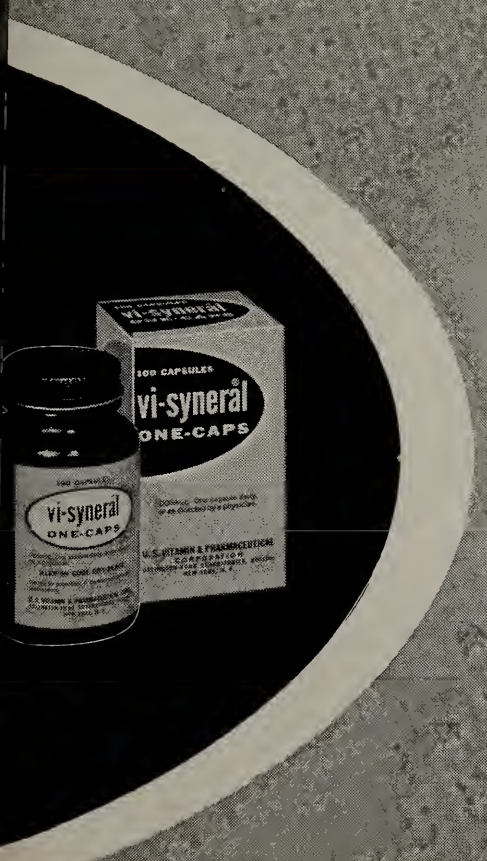
3. Such services in hospitals should be under the direction of the appropriate department or section charged with the responsibility for the maintenance of that type of service; and be it further

RESOLVED: That the following list of scientific professional and technical personnel in the health fields be a representative list of allied health professions and services that may be added to or deleted therefrom at the discretion of the governing body of MSMS:

1. Anatomists
2. Audiologists
3. Basal metabolic technicians
4. Bioanalysts
5. Biochemists
6. Biophysicists
7. Biostatisticians
8. Chiropodists
9. Clinical chemists
10. Corrective therapists
11. Cyto-technologists
12. Dietitians
13. Electrocardiographic technicians
14. Electroencephalographic technicians
15. Electrologists
16. Epidemiologists
17. Histologic technicians
18. Hospital administrators
19. Industrial hygienists
20. Inhalation therapy technicians
 (Oxygen therapy technicians)
21. Lay psychoanalysts
22. Masseurs and mechano-therapists
23. Medical illustrators
24. Medical record librarians
25. Medical social workers
26. Medical technologists
27. Microbiologists
 Bacteriologists
 Immuno-serologists
 Mycologists
 Parasitologists
 Virologists
28. Midwives
29. Music therapists
30. Nutritionists
31. Occupational therapists
32. Opticians
33. Optometrists
34. Orthoptic technicians
35. Pharmacists
36. Pharmacologists
37. Physical therapists
38. Physiologists
39. Prosthetists
40. Psychiatric social workers
41. Psychologists
 Clinical psychologists
 Counseling and guidance psychologists
42. Public health educators
43. Radiation therapy technicians
44. Recreational therapists
45. Rehabilitation therapists
46. Sanitary engineers
47. Sanitary inspectors
48. Speech therapists
 (Speech pathologists)
49. Vocational counselors
50. X-ray technicians

and be it further

RESOLVED: That MSMS transmit this statement of policy to the constituent county societies.



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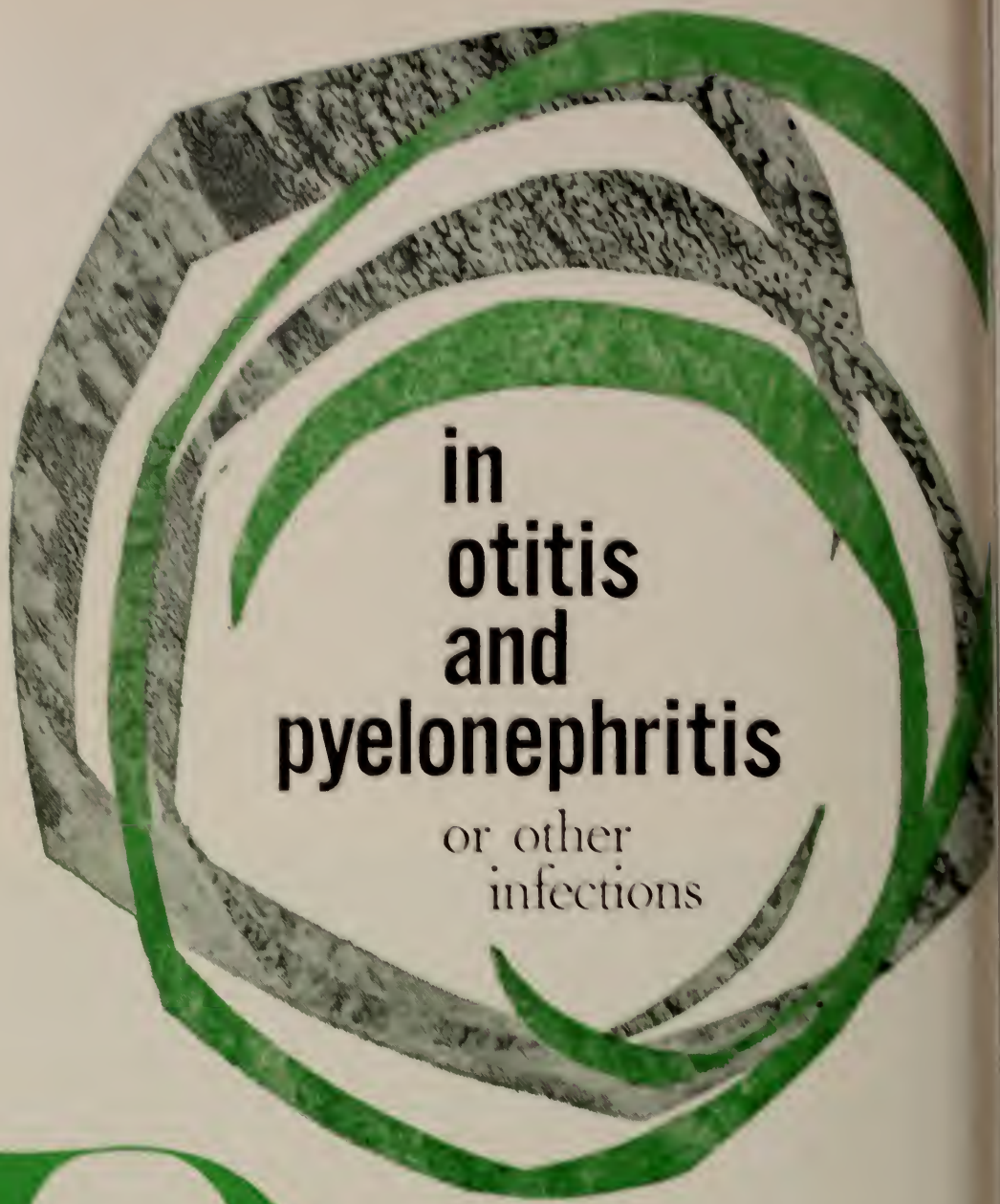
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PYRIDOXINE HCl (B_6)	1 mg.	COPPER	1 mg.
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VITAMIN B_{12}	3 mcg.	MANGANESE	1 mg.
d, CALCIUM PANTOTHENATE	5 mg.	MAGNESIUM	1 mg.
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Medicine in Action

Programs Outlined at AMA Institute Chicago, August 31, September 1, 1961



Second of a two part report by R. W. Teed, M.D., to The Council of MSMS about the recent AMA Institute in Chicago—Part I appeared in the October issue.

Reporting on the activities of the AMA, F. J. L. Blasingame, M.D., Executive Vice President of AMA, pointed out that although AMA membership is at an all-time high (180,000), too many physicians remain outside. A program of invitation and solicitation should be carried out to attract these men.

Regarding meetings, he asked if improvement could not be made. He suggested biennial or triennial conferences on various subjects such as rehabilitation, nutrition, and medical education.

He stated that while undergraduate medical education tries to be objective in dealing with curricula and other programs, faculties have not been used efficiently to accommodate more students. He suggested the utilization of beds in private hospitals in cities having university medical schools, and the use of international teachers such as those from Cuba, East Germany, and elsewhere.

* * *

THE DEVELOPMENT of a true self-policing program could be of the greatest value to medicine, he stated, and suggested that Medical Ethics be more than a term.

A program to study medical care costs would also be of great value, particularly if it led to a means by which costs could be reduced.

Regarding medical economics and voluntary insurance, he stated that the AMA should improve its library on the subject, and stimulate research. Much still needs to be done, and the AMA should lead.

In regard to the AMA legislative program, he urged continued efforts in our opposition to the King-Anderson Bill. Medicine must remain alert to the danger, and support the AMA in this fight. At present, from 2 to 4 per cent of the AMA budget is used in this effort, and it does not seem now that any more will be needed.

Dr. Lyman Smith (AMA Honors, Scholarship and Loan Program) spoke on a subject which has recently been studied carefully by the MSMS Subcommittee on Medical Recruitment. He pointed out that the medical student pays more than double in fees than the Ph.D. candidate, while averaging about $2000 in scholarships for 4 years, in comparison with the Ph.D.'s assistance of about $8000. Thus there is an 8-1 disparity against the medical student. It is not surprising therefore to find that the majority of medical students come from families receiving more than $10,000 per year.

* * *

THE AMA IS TRYING to attract a larger number of high-

quality students, but needs the help of state societies. In this effort the AMA can give (1) leadership, (2) ideas, (3) financial support, and (4) honors program stressing scholarship.

The talk given by Professor Paul Peterson (Associate Professor of Journalism, University of Omaha, Nebraska) was particularly valuable because of its frank nature, and because it represented ideas actually held by people. While he spoke of the AMA, his remarks had equal value for state societies.

He stated that the public image of the AMA is not favorable; that it is chillier than that of 10-12 years ago. Evidently, the esteem of the AMA has not kept pace with medical advances. The public believes the AMA is characterized by a negative attitude, and holds that it is a tight guild seeking to keep its membership limited and its income high. Only when threatened does it seem to come to life. That these opinions are incorrect is unimportant—the fact is that they are held. One physician charged with malpractice makes the whole group look bad.

Many people believe that the goals of the AMA are not consistent with the good of the public, but that it is protecting its income. Some think the "M" stands for money. The average citizen believes that the AMA does not touch him directly and is not concerned with him.

Governor Pat Brown of California was quoted as saying that if the AMA does not clean its own house, the government will step in and do it. He labelled 4,000 doctors as being incompetent, although he gave no indication as to how this judgment was reached.

* * *

ADVANCES IN MEDICINE have been so spectacular that the public has come to expect miracles daily. Alton Blakeslee was quoted as saying that the public thinks we should eliminate heart disease, cancer and other dread diseases. If a patient is not cured of his sore throat at once he loses confidence.

There have been an increasing number of articles in magazines favorable to medicine, and these should have a good effect. These, plus the work of public relations men, are good, but they cannot create something that does not exist. The key is in the hands of the individual doctor.

Stresses Importance Of Speakers Bureaus

(The importance of speakers bureaus in effectively telling the story of Medicine is being stressed by the American Medical Association. A spokesman for the AMA Speakers Bureau offers this advice to interested component societies and specialty groups)

"You would be surprised at how many physicians do not know the AMA story. It has been told literally thousands of times across the nation. Yet major public figures are still telling Americans that the AMA opposed Social Security, that the AMA was against the Red Cross blood program, that the AMA opposes all progressive legislation for the good of the people.

"If you cannot answer those three charges about Social Security, Red Cross blood programs, and opposition to all legislation, you definitely need to read the booklet 'Basic Facts About the AMA.'

"A speakers bureau has a goal—getting the facts to as many members of the public about this vital aging issue in the most effective manner possible. This helps create a climate for action to aid the aged and other needy under freedom of medicine and preservation of the doctor-patient relationship, rather than under government medicine.

"The first task is selecting a list of speakers. You are that first group, and I hope there will be many others to follow. Just what makes a good speaker is a hard thing to determine.

"The second step is training the speakers. Actually, the training process continues through a speaker's career. The speaker is always learning and willing to learn. Part of the training is technique. Another equally important part is keeping informed on the issues. No matter how good the speaker is, he or she must know the facts.

"Now you have a group of trained speakers awaiting action. They need to be put to work, which means the public must be told about them. There are several methods of doing this. One is to put out a brochure telling about the speakers bureau, its purpose and goals, some of the members who are best known, and how a group or organization gets such a speaker. Circulate this brochure to every group in the state which uses speakers.

"Another method is to write a letter to the organization telling them the same information. A good combination would be a covering letter along with a brochure.

"This should and will bring in quite a few requests. More will follow as the bureau becomes better known and the word gets around that this is a good way to have a top program. But follow-up contacts with organizations should be made whenever society members are dealing with a specific group.

"Most times the story about your talk reaches more persons than your talk. So it is a must that there be advance publicity and a story on the talk. If they need an advance text, be sure they get it.

"As you can see, a speakers bureau has tremendous potential, and each of you has the opportunity of being right in the middle of it. You can gain favorable publicity for the Michigan State Medical Society and AMA. You can establish good liaison with organizations and a basis for future cooperation, including resolutions opposing this approach to medical care for the aged. You can discover and develop future Ed Annises. You can make a sound contribution to communications of organized medicine. You can help sell free enterprise and individual freedom."

Successful Resuscitation of Cardiac Arrest In Acute Coronary Occlusion

Edward J. Klopp, Jr., M.D.
Lloyd E. Verity, M.D.
Sherwood B. Winslow, M.D.
Battle Creek, Michigan



THE PROBLEM of cardiac arrest has been of interest to surgeons for many years and its occurrence within the operating room has been well appreciated to the point that no surgeon who has not been thoroughly indoctrinated into the steps of cardiac resuscitation, will undertake an operation today. However, cardiac arrest outside the operating room has occurred rather frequently. The number of patients who have been successfully resuscitated, in such instances, is not completely known. The cause of cardiac arrest outside the operating room has usually been ascribed to acute myocardial ischemia due to sudden coronary artery occlusion. It is a case of this type which we shall present at this time. Recently, we have also encountered cardiac arrest following accidental industrial electrocution, which will be the subject of another communication.

Reagan et al[13] and Beck et al[2] presented the first two cases of successful resuscitation outside the operating room in 1956. Since that time, interest has increased to the point that in some hospitals regular teams are available for cardiac resuscitation on all patients who come in with a serious "heart attack." The case we are about to present occurred in a hospital under rather fortuitous circumstances, but without an organized team.

Case Presentation

L. R. K., a physician, aged fifty-two, was working on his charts in the medical library of the Leila Y. Post Montgomery Hospital, when he was suddenly seized with severe upper abdominal and low substernal pain. There was a constricting sensation, with a feeling of a weight on his chest, but without radiation of the pain. He was given morphine sulphate, grs. ¼, hypodermically and transported to the only available bed in the hospital, located in the treatment room on the surgical floor.

Prior to this attack, he had been seen by one of his very close friends, a physician who discussed non-medical matters with him, and he seemed perfectly well. Therefore, we can assume that this attack, which occurred shortly after 9:00 a.m., had no premonitory symptoms.

Upon examination, slight pallor and sweating were observed, but no shock. The heart tones were clear and distinct; there were no murmurs and no irregularity. The blood pressure was 120/74. The patient denied any previous history of angina or prior episodes of similar pain. Thirty minutes later, the patient still complained of substernal distress. In the presence of a physician, he had a sudden convulsive seizure. The head, neck and chest became intensely red (lobster red). Shortly, cyanosis occurred, and respirations ceased. His visitor pounded upon the patient's chest and called for help. The diagnosis of cardiac arrest was confirmed, and a thoracotomy was decided upon. Of interest, and of some embarrassment, was the fact that no scalpel

could be found on the surgical floor. Therefore, the unprepared chest was opened with a penknife, and massage was started through the intact pericardium while an anesthetist was summoned and a thoracotomy set obtained. The period of time between the convulsive seizure and the opening of the chest is estimated at between five and seven minutes.



Fig. 1

After a rib spreader was inserted, the pericardium was opened and massage directly on the heart was initiated. An electrocardiograph revealed gross irregularity with intraventricular block. During the process of massage and attempted resuscitation, it was noted that ventricular fibrillation would occur and spontaneously disappear. Circulation was maintained by cardiac massage, while oxygenation of the lungs was accomplished by mask breathing with an anesthesia machine for somewhere between one and one-half to two hours. During that period of time, small amounts of adrenalin were injected directly into the right ventricle (during the periods when no gross fibrillation was observed). A continuous drip of 4 cc. of levophed and 250 cc. of normal saline was started into the ascending aorta (both coramine and procaine had been used without effect). A pacemaker, with electrodes attached directly on the heart, was used without effect. Finally, during a period of very obvious gross ventricular fibrillation, a defibrillator was applied with 110 volts and 0.5 amperes, giving three successive shocks. The rhythm immediately changed from fibrillation to sinus rhythm. During the last twenty minutes of massage, spontaneous respirations occurred. The patient thrashed about during the closure of the chest and insertion of intercostal chest tube. At no time was the patient moved from the treatment room.

Intravenous infusion of levophed 8 cc. to 1000 cc. of glucose was necessary to maintain the blood pressure above 80 mm. Hg., systolic. The drip was regulated in an attempt to maintain the pressure at 100 mm. Hg., systolic. The patient was completely irrational, requiring sedation of sparine and morphine for the first forty-eight hours. At the end of this time, he asked a few rational questions, but had complete loss of memory. On the fourth day after the cardiac arrest, cerebration was returning. At this time, his pulse was rapid and of rather poor quality, although he had received digitalization dosage of cedilanid. On the second postoperative day, he started taking coffee, and a soft diet on the third day. On the fourth postoperative day, his temperature rectally was 102.8 degrees F., and thereafter gradually went down to a normal level. By the tenth postoperative day, his temperature was normal for the full twenty-four hours. His condition generally improved, and his mental faculties returned to normal. Râles heard at the base of his lungs for the first four or five days postoperatively gradually disappeared. The patient was discharged from the hospital approximately six weeks later. At the time of discharge, he was able to walk in the halls of the hospital and to talk intelligently with those around him.

Chest x-ray examination revealed normal postoperative reaction in the pleura. At the time of closure, the pericardium was left open. On some of the radiographs, it appeared that a ventricular aneurysm might be present. However, a radiograph taken four months later (Fig. 1) showed some enlargement of the left ventricle, but no aneurysmal bulging, and this was confirmed by fluoroscopic examination.

Electrocardiograph taken four months afterwards showed the healing phase of an anteroseptal-lateral infarct with considerable myocardial ischemia (deeply inverted T waves in lead 1, and all precordial leads) (Fig. 2). There was no elevation of segments to suggest the presence of a ventricular aneurysm.

The laboratory tests gave essentially normal findings except for a sedimentation rate of 62. The total cholesterol was 231 mgm. per cent; NPN 35 mgm. per cent; serum electrolytes of sodium, potassium and chlorides were normal.

The past history of the patient revealed that he had scarlet fever, the usual childhood diseases, one episode of a renal calculus which passed spontaneously, and a tonsillectomy and adenoidectomy. Of interest in his family history was the fact that his father lived to be eighty-four, died of an enlarged heart, and had one non-disabling stroke. His mother also died at the age of eighty-four of generalized arteriosclerosis. One brother died in infancy of scarlet fever. Another brother died in infancy of meningitis. One brother died at the age of forty-nine of carcinoma of the kidney. He has three sisters and one brother living and well.

At the present time, this patient remembers the pain which occurred when he was in the library, remembers receiving the hypodermic injection and being placed in a wheel chair. From this point on, his memory skips until about three to four days postoperatively. Aside from this amnesia, there are no mental aberrations. This patient has done physical work, in the form of pulling up tree roots, and has resumed his duties as president of his county medical society.

Discussion

This case presents several interesting features. The delay before establishing oxygenation of the brain by direct massage of the heart appears to have been prolonged. However, the physician in the room at the time of the convulsion did pound on the chest. It is entirely possible that he was able to maintain oxygenation of the brain in this manner, as recently described by Kowenhoven et al, as "closed chest car-

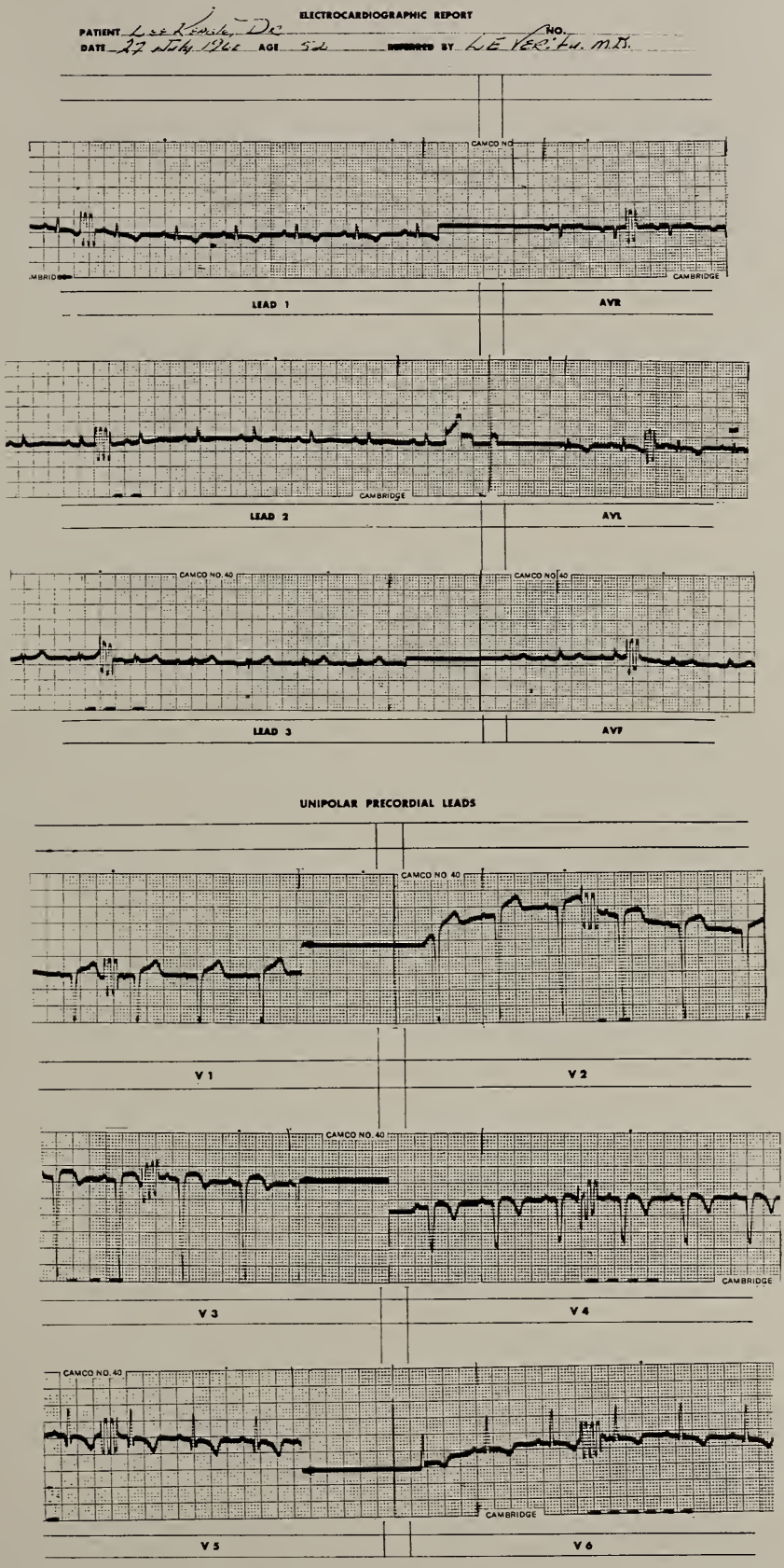

ELECTROCARDIOGRAPHIC REPORT
PATIENT Lee Kerste, Dr. NO.
DATE 27 July 1961 AGE 52 REFERRED BY LEVERTH. M.D.
CAMCO NO.
CAMBRIDGE
LEAD 1
AVR
LEAD 2
AVL
CAMCO NO. 40
LEAD 3
AVF
UNIPOLAR PRECORDIAL LEADS
V 1
V 2
V 3
V 4
V 5
V 6

Fig. 2

diac massage."[7] In addition, a case was reported by Schlackleman et al in 1958, "Cardiac Arrest Following Abdominal Operation,"[15] when ninety minutes elapsed before opening the chest to massage the heart directly. Prior to opening the chest, various measures, such as use of the pacemaker and compression of the chest, were used without obvious effect, and this patient made a full recovery.

Stephenson,[22] in his study of more than 1200 cases of patients with cardiac arrest, found that of the survivors, only six per cent survived if the arrest was over four minutes before massage was done and ninety-four per cent if massage was instituted within that time. In cases of Turk et al,[25] there were only two successful cardiac resuscitations in twenty cases of cardiac arrest occurring in the patient's room, and one in a constant temperature room. Out of forty-four cases of cardiac arrest, there were seven survivors, four occurring in the operating room. Stahlgren et al[21] reported twenty-five patients with cardiac arrest outside of the operating room upon whom resuscitation was attempted. One patient survived (four per cent).

The penknife, as an instrument to open the chest, has been used in one case reported by Brown et al.[5] Successful resuscitation outside the operating room of a physician was first reported by Beck et al[2] in 1956.

There are at least eleven cases recorded in the literature of successful cardiac resuscitation outside of the operating room. There may be many more that have not been reported. We feel that this case points out the growing need for facilities for cardiac resuscitation, not only in the operating room, but in other areas of the hospital as well. Although the instances of successful resuscitation at the present time are not great, with more experience and with a greater number of trained personnel available, the patient with severe myocardial infarction has a better chance to survive cardiac arrest.

Summary

A case of cardiac arrest in a physician, aged fifty-two, occurring outside the operating room, and following an attack of coronary artery occlusion, has been presented with a brief review of the literature.

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Superficial Phlebitis of the Breast And Chest Wall: Mondor's Disease

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THROMBOPHLEBITIS of the anterior chest wall and mammary region occurs infrequently, and since 1939 has commonly been referred to as Mondor's disease in keeping with French surgeon Henri Mondor's description of "string phlebitis of the chest wall." The first recognition of this clinical entity was credited to Flagge, who in 1869 described a breast which "presents a deep, puckered groove, looking exactly as if it were a scar after an operation for removal of the organ and extending into the axilla." Farrow[2] reported forty-three cases from a large Breast Service at Memorial Center, New York, in 1955 (covering an eight-year period, 1947 through 1954) and found fifty-eight additional cases in the world literature. Kaufman[5] reported seven cases a year later, Karlan and Traphagen[4] described a case in 1957, and Honig and Rado[3] added eight more cases in 1960.

At times, this condition has been confused with cancer, leading to uncertainty of the correct treatment and emphasizing the importance of bringing Mondor's disease, a completely benign condition, to the attention of physicians and surgeons who may not be aware of its existence. It has also been confused with scleroderma, as noted in one of the following case reports.

This is a phlebitis and periphlebitis of the lateral thoracic or thoraco-epigastric vein, often spreading over the chest wall and by communicating branches to the superficial venous plexus over the anterior abdominal wall. Although injury, surgical trauma and infection play major roles in its inception, the phlebitis may be spontaneous or idiopathic, with an obscure etiology. About one-third of the reported cases were in men but the typical case is a woman between the ages of twenty-one and sixty-five years, with heavy or "fleshy" breasts, and the left breast or chest wall is most often affected. Rarely, there is bilateral chest involvement. Mondor's "syndrome" is entirely distinct from an entity Waugh described as mammary arteritis, a discrete nodular breast tumor requiring excision biopsy to exclude neoplasm. This has been compared to temporal arteritis.

Usually, there are symptoms of sudden pain and tenderness of mild to moderate severity. This pain may be referred to the axilla or to the abdomen; may be aggravated by raising the arm, by exercise which stretches the abdominal muscles, or by deep breathing. In some instances, the patient has noticed a groove in the skin or a subcutaneous cord; occasionally, there is a linear reddening of the skin.

A tender fibrous subcutaneous cord from 3 to 5 millimeters in diameter, of variable length up to 28 centimeters, is the characteristic physical finding. This is attached to the skin, and in the typical case when the breast or arm is raised, a narrow and shallow groove can be seen in the skin. The linear depression may bifurcate into one or more branches. The cord has a consistency similar to that of the vas deferens, usually is solid, but may have a beaded character, and fades indistinctly into the subcutaneous fat. When cut, it retracts suddenly like a cut bow string.

There is no consistent time interval for the signs and symptoms; this is a self-limited condition which does not appear to be influenced by any specific treatment. Farrow states that "symptoms had been present from a few days to four months before examination; average duration was about two weeks." In his series, symptoms usually subsided in about two weeks, and the palpable cord-like structure disappeared in six weeks to two months, although ten months were required for its disappearance in one case. Although he had follow-up examinations of only eight of his forty-three cases, there were no recurrences one to six years after recovery.

Rest and applications of warm compresses are sufficient to relieve symptoms in the majority of cases. Antibiotics and anticoagulants have been used without any definite physical response other than some relief of the pain and tenderness (but did not cause early disappearance of the subcutaneous cord in any of the cases reported).

In instances of superficial thrombophlebitis of the breast and chest wall of obscure origin, where malignancy cannot be ruled out, a biopsy should certainly be done. Calvet[1] reported a patient in whom a breast tumor was excised locally and found to be malignant, but radical mastectomy was refused. The woman returned later with a cord-like strand extend-

ing from the involved breast to the umbilicus, but this time the surgeon reasoned erroneously that this was lymphatic permeation by carcinoma, rendering the lesion unsuitable for surgical removal. It is now known that benign superficial thrombophlebitis occasionally follows biopsy of the breast and should not be confused with carcinoma.

Case 1.—A. B., a white, active registered nurse, aged forty-five, underwent partial right mastectomy (nipple and large central wedge resection, removing slightly less than one-half of the breast) on March 23, 1961. Frozen section was negative for malignancy, and the final pathological report was benign cystic mastitis. The indication for this operation was redness and a moist vesicular eruption of the right nipple and areola of three months' duration, a recurrent lesion which had its onset in November, 1958. Biopsy of this same nipple and excision of a ductal area above it had been done on March 22, 1960, with a pathological diagnosis of benign mastitis.

There was persistent serous drainage from the incision, and on April 26, 1961, the patient noticed soreness well below the right breast. Examination revealed a linear area of phlebitis, cord-like, from the breast down through the abdominal wall to the iliac crest. Coumadin therapy seemed to relieve the tenderness, along with hot compresses. She was given Chymoral tablets for a few days without much change in the tender cord. An examination done June 6 showed persistent intermittent tenderness in the abdomen, and a "beaded" cord was palpable to the level of her umbilicus. A final examination on August 4, almost five months postoperatively, revealed a firm cord extending from the breast to a point just below the right costal margin and no definite tenderness. This complication produced enough discomfort to cause the patient to stop work for almost ten days, two weeks after she had returned to her hospital duties, with the breast incision well healed.

Case 2.—M. H., a white waitress, aged thirty-four, entered the hospital on May 2, 1955 for excision of a small, red, indurated lesion above the left nipple, which was first noticed three months before admission. The lesion was removed on May 3 with pathological report of benign fibroadenoma. Healing was slow, requiring almost four weeks. On September 15, a "raised streak 5 centimeters in length" was biopsied and reported as early scleroderma or some other collagen disease. The patient returned for examination on October 7, 1955, because of tenderness below the left breast, and a tender cord could be felt from the left nipple well down onto the chest wall. This disappeared in a few weeks and was not apparent on reexamination on December 12, 1955.

Because of persistent tenderness and firm swellings above and beneath the left nipple, a wedge resection of this area was done on May 28, 1956, and the tissue was reported as fibroadenoma and normal scar tissue. On June 27, one month later, a ropy cord was noted under the left breast, coursing down onto the chest wall. Three weeks later, on July 18, the tender cord extended down onto the abdomen and persisted for several months, being described as a "very fine line" from breast to abdomen on an examination done December 1, 1956. Small doses of oral Cortisone for a period of four weeks relieved the tenderness. The patient was hospitalized on July 19, 1961 for a back injury, and there was no evidence of the old phlebitis of the left chest wall.

Case 3.—D. R., a white housewife, aged twenty-four, complained of painful breasts in 1951, clinically diagnosed as benign cystic mastitis. Because of persistent pain and a discrete swelling in the left axilla, she was hospitalized, and on April 6, 1954, two separate incisions were made to remove the axillary gland and a small cystic area above the left nipple. The pathologist reported the lesions as cystic mastitis with adenosis and benign lymphadenitis. Both incisions healed normally.

Four months later, on office examination done August 2 (because of recurrent pain in the left breast and chest), there was a firm, tender cord extending from the left nipple upwards to the left clavicle. The patient was given Cortef 20 milligrams twice daily for one week, then once daily for another week plus the use of hot packs. The symptoms and cord disappeared in four weeks. On examination October 6, 1954, there was a small, tender matted area above the left nipple, one palpable left axillary node and a few palpable left cervical lymph glands, but the cord had disappeared.

New areas of swelling, tenderness of the left breast and the persistent left axillary gland led to hospitalization again and on July 11, 1955, a mass above the left nipple and a large gland of the left axilla were removed. Pathological diagnosis was adenosis, benign, and non-specific lymphadenitis. The incisions healed promptly, and the phlebitis did not recur. When last seen, on May 25, 1960, there was no apparent lesion of the breast or chest wall.

Summary

Three additional cases of Mondor's disease are presented, each one following a minor surgical procedure on the female breast. Scleroderma was the original diagnosis in Case 2, but was definitely ruled out in the subsequent illness. Steroid therapy, not mentioned in the previous medical literature, was used in two of the cases and appeared to relieve tenderness, although there was no positive evidence that it hastened recovery. The benign nature of this disease and its eventual complete recovery is emphasized.

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25 West Michigan Avenue

Cerebral Angiography in a Community Hospital

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CEREBRAL angiography, introduced in 1927 by Egas Moniz, has assumed a major role in the objective diagnosis and localization of intracranial lesions. As the technique has become simplified and the scope enlarged, this examination has found application in the small community hospital as well as the medical center. This development has been responsible in part for the increased practice of neurological surgery in the smaller cities.

The indication for angiography is simply the suspicion of a lesion of the brain or its vascular supply. There are no valid contraindications in a case where there is a reasonable chance of improving the patient's condition as a result of obtaining more precise knowledge of the identity and location of the pathologic condition.

Angiography has several advantages over air studies. It is equal or superior to ventriculography in the information derived. It can be readily done on an outpatient. Perhaps most important is the lack of physiologic change in the examined patient so that a positive angiogram does not require immediate surgery.

The examination ordinarily is done under local anesthesia by the percutaneous technique. Sodium pentothal anesthesia has been reserved for children and very nervous or irrational adults. The cutdown technique with cannulation of the artery is used only when percutaneous attempts are unsuccessful. A dosage of 10 cc. of Hypaque sodium is used for each injection. This has resulted in good contrast and only two serious reactions in the entire series. Both patients showed temporary convulsive seizures and cyanosis. There have been no paralyses or deaths as a result of these studies.

Our radiographic equipment is conventional and multipurpose with exposures in the 60 to 85 kv. range, 200 ma. at 1/4 second. A single anteroposterior view is taken on the first injection and two lateral views on the second. These are made without moving the patient with a horizontal beam and grid cassettes, and satisfactory filling in both the arterial and venous phase is easily demonstrated. We have not found the lack of a rapid film changer critical in a single case and, therefore, we are unwilling to accept the increased radiologic exposure inherent in this equipment, despite its advantages in some areas.

In the four years since this study was initiated, we have performed 233 cerebral angiograms on 181 patients, ranging in age from twenty-two months to eighty-five years. The ratio of male to female patients was 5:4. Our results are summarized in the accompanying tabulation.

Negative	93	
Tumor	25	
Aneurysm	20	
Vascular plaque and/or thrombus	19	
Arteriovenous malformation	10	
Subdural hematoma	8	
Technically unsatisfactory	4	
Abnormal unclassified	2	
Total	181	patients

Each patient is classified by his primary diagnosis at the time of the study. Several of the "tumors" proved to be metastatic, one an intracerebral hematoma without a traumatic history, and one a cystic hygroma over the temporal lobe. Many patients had two or more aneurysms but are recorded as "aneurysm" only. In the same vein, two of our patients had bilateral subdural hematomas (see Case 1) and most of the arteriovenous malformations had evidence also of an intracerebral clot. Cases classified as vascular plaques and thrombi had either complete obstruction or pronounced localized narrowing of the lumen (see Case 2), which was considered the cause of the symptoms. Plaques noted incidentally were recorded as negative. Of our technically unsatisfactory group, three had carotid sheath extravasations and associated arterial spasm (and were subsequently evaluated by other means). The fourth patient developed marked nausea and vomiting and refused further study. Of the "negative" group, three were demonstrated to have significant lesions by ventriculography.



Fig. 1



Fig. 2

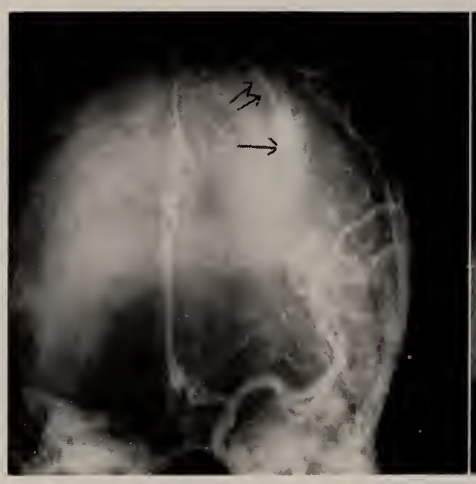


Fig. 3

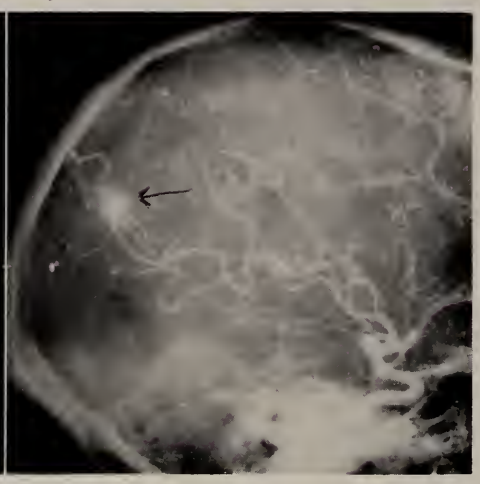


Fig. 4

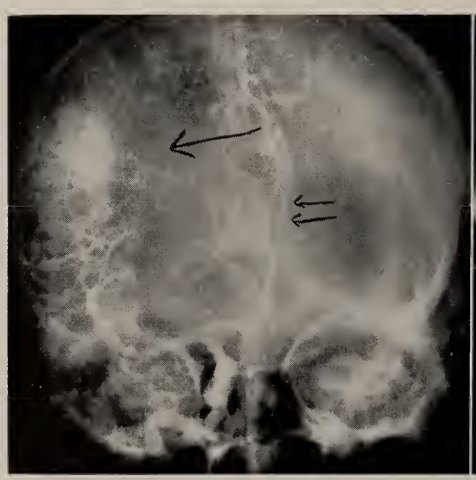


Fig. 5

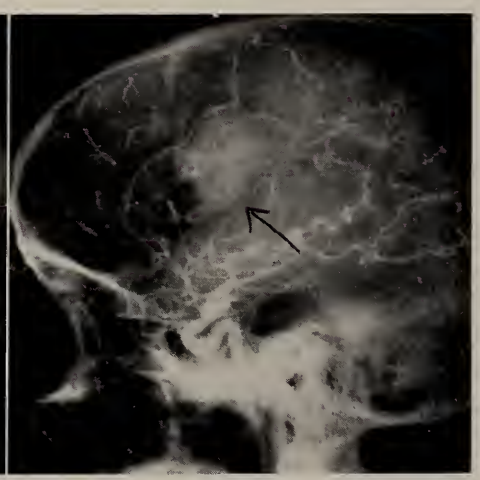


Fig. 6



Fig. 7 Fig. 8 Fig. 9

Case 1.—A man, aged fifty-seven, was seen ten weeks following an automobile accident in which he had suffered a laceration of the forehead and a concussion. He was discharged from another hospital after forty-eight hours observation and was well except for intermittent headaches. The headaches became severe two days before admission, and he became increasingly somnolent. The optic discs showed questionable papilledema, and neurological examination was otherwise negative. Lumbar puncture produced clear, colorless normal fluid, and skull radiographs showed no abnormalities.

Left carotid arteriography demonstrated separation of the branches of the middle cerebral artery overlying the lateral aspect of the cortex from the internal table of the skull (single arrow, Fig. 1). This identified the position and suggested the size of the chronic *left* subdural hematoma. The lack of displacement of the anterior cerebral artery to the right (double arrows, Fig. 1) was considered adequate evidence of a corresponding *right* subdural hematoma. Both hematomas were evacuated at surgery.

Case 2.—A woman, aged sixty-three, suffered an attack of "dizziness" and right-sided weakness which cleared spontaneously in a few hours. Three days later, she veered to the left while climbing stairs and "couldn't make the right foot go." Examination revealed only mild right hemiparesis with slight exaggeration of the deep tendon reflexes on this side. Our impression was left carotid artery insufficiency.

A left carotid arteriogram demonstrated marked narrowing of the internal carotid at its origin by a well-developed plaque (Fig. 2). Following this, the minimal findings cleared completely, to be followed six weeks later by headache, "left eye out of focus," left retro-orbital pain, nausea and vomiting. Physical examination again indicated the patient to be entirely normal, but she was scheduled for thromboendarterectomy the next morning. She suffered complete occlusion with right hemiplegia during the night. This was unrelieved by surgery.

Case 3.—A woman, aged forty-eight, had a convulsion and became unconscious as a dentist was injecting procaine. She was examined by a physician who ruled out an anaphylactic reaction and referred her to us in coma, with a right hemiparesis and a left pupil which was smaller than the right. Lumbar puncture revealed grossly bloody fluid with a pressure of 200 mm. of water.

A left carotid arteriogram showed an arteriovenous malformation arising at the terminal end of the posterior parietal artery (single arrow, Figs. 3 and 4) draining into the superior saggital sinus (double arrows, Fig. 3). The decreased peripheral resistance is manifested by the dilatation of the "feeder" artery and the fact that it is filled so peripherally while the remainder of the vessels are in mid-arterial phase. These physiologic changes explain our "luck" in demonstrating such a peripheral lesion without the special timing available with a film changer.

At surgery, an adjacent intracerebral clot was evacuated and the vessels clipped. A postoperative angiogram showed marked decrease in blood flow through a very much smaller malformation.

Case 4.—A woman, aged fifty-four, had had left sided headaches and seizures for three years, when first seen, with occasional loss of consciousness. She described numbness of the left side of the face associated with some twitching, a "far-off feeling" and an associated odor of hot metals when none were present. For six months, the left arm had been quite weak and she was beginning to have increasingly severe headaches. Electroencephalography revealed a focal lesion in the right posterior frontal area. Physical examination gave entirely negative findings.

A right carotid arteriogram revealed a "tumor stain" which lasted well into the venous phase (single arrow, Figs. 5 and 6). The anterior cerebral was shifted to the left (double arrow, Fig. 5) and the middle cerebral group depressed (Fig. 6). The diagnosis of angioblastic meningioma was confirmed at surgery.

Case 5.—A woman, aged sixty-seven, developed sudden, almost complete ptosis of the left eyelid associated with some blurring of vision. She consulted her ophthalmologist who

found ptosis of the left lid associated with a large pupil which responded sluggishly to light and referred her to us with the diagnosis of "aneurysm in the Circle of Willis."

The left carotid arteriogram revealed an aneurysm arising from the internal carotid near the origin of the posterior communicating artery (single arrow, Figs. 7, 8 and 9). The oblique view (Fig. 9) was obtained, as aneurysms are commonly poorly demonstrated on one of the conventional views (Fig. 7, in this case). It is probably sound practice to include this view and to map the opposite side, as well, in these patients prior to surgery, as the defects are frequently multiple and bilateral.

Summary

We have reviewed our experience with 233 carotid arteriograms in 181 patients seen in the past four years. The studies were performed in two 180-bed community hospitals with conventional multipurpose equipment. The absence of a rapid film changer has not proved critical in a single case.

How to Save Lives on Michigan's Highways

(Summary of remarks of John R. Rodger, M.D., Michigan Health Conference, Flint, May 25, 1961)

The Problem

There were 1,600 traffic deaths in Michigan in 1960, which is an increase of 125 over the previous year. Approximately three times this number were permanently disabled. Half of the deaths were in the age group of 25 to 65, but two-thirds of drivers involved in fatal accidents were in this same age group.

Partial Solutions

1. Install seat belts on all cars, new and old. This would save an estimated 5,000 lives in the United States, and 200 in Michigan. It has been scientifically proven that the wearing of a seat belt reduces the chance of serious injury or death by at least 35 per cent. The 1962 cars will have seat belt attachments as standard equipment. The Governor has recently ordered seat belt installations on state-owned cars on a voluntary basis.

2. Purchase new cars with other safety features in mind, i.e., padded dash, avoidance of sharp objects on the instrument panel, two-door models where there are small children or else safety catches on four-door models, avoidance of colors hard to see on the highway or in snow, et cetera.

3. Avoid "wool-gathering" at the wheel. 85 per cent of accidents occur to drivers who have never had a serious accident before. If all accident repeaters were removed from the highways, total accidents would decline by less than 4 per cent.

4. Be in the best possible physical condition when you drive. Do not drive if you are having dizzy or black-out spells, if your vision is poor, if you are taking drugs which cause drowsiness, or if you are overly tired.

5. Do not mix alcohol and gasoline; 50 per cent of our serious accidents involve drinking to some degree, and as little as two cocktails or two beers can be dangerous. The unnecessary deaths and injuries from drinking and driving will continue until we become stricter with ourselves and support stricter enforcement measures.

6. We are "our brother's keeper" on the highway, too.

Wisconsin Requires Auto Seat Belts

A long campaign by the State Medical Society of Wisconsin reached a successful conclusion recently when Governor Gaylord Nelson signed a law making front seat safety belts mandatory equipment on all new cars sold in the state.

The society had advocated such a law for the past several sessions of the legislature and had met with partial success one year when the legislators approved a resolution urging that all state vehicles be equipped with the belts.

Passage of the law makes Wisconsin the first state to require safety belts as part of a car's equipment. The law applies to all new cars, beginning with the 1962 models.

Calhoun County Medical Society

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THE CALHOUN County Medical Society was organized on November 11, 1839, in the village of Marshall. A Constitution and By-laws were adopted and the following officers elected:

President.....Luther W. Hart, M.D., Marshall
Vice-President.....D. B. Crane, M.D., Albion
Secretary.....J. H. Montgomery, M.D., Marshall
Treasurer.....W. Thompson, M.D., Marshall
Censors.....Drs. Crane, Montgomery, Devitt, Sibley and Greaves

The membership included A. L. Hayes, M.D., Marshall, first physician in the county, who came in 1831.

The first Calhoun County Medical Society accepted members up to 1854, and one in 1863; the roster contained names of seventeen doctors from Marshall, which was the most prominent area, four from Albion, three from Homer, and one each from Marengo, Teconsha, Burlington and Bedford. Battle Creek, which came into prominence later, had twelve members.

The first Calhoun County Medical Society went the way of many other medical societies. It disappeared before or during the Civil War. Although the old records are not now available, the present Calhoun County Medical Society is the second one organized, just as the present Michigan State Medical Society is the third formally organized group.

On November 17, 1876, a letter was sent to all the physicians of the Calhoun County area, calling a meeting to reorganize the Calhoun County Medical Society. It was signed by John P. Stoddard, M.D., Amos Crosby, M.D., and J. H. Montgomery, M.D. On December 4, 1876, a large number of physicians attended, and an organization was established with J. H. Montgomery, M.D., Marshall, President; Edward Cox, M.D., Battle Creek, First Vice President; O. S. Phelps, M.D., Homer, Second Vice President; John P. Stoddard, M.D., Albion, Secretary; M. A. Garcia, M.D., Battle Creek, Treasurer. Standing committees were appointed on "Ethics and Grievances," "Public Health and Hygiene," "Epidemics and Endemics," "Relations with Jurisprudence." Diphtheria was selected as the subject for discussion at the next meeting. The initiation fee was fixed at $1, and the annual tax or dues at 50 cents.

The charter members were J. H. Montgomery, M.D., Marshall; Edward Cox, M.D., Battle Creek; Mark W. Tomlinson, M.D., Battle Creek; Amos Crosby, M.D., Albion; John P. Stoddard, M.D., Albion; O. S. Phelps, M.D., Homer; L. A. Foote, M.D., Vermontville; J. H. Smiley, M.D., Marshall; J. B. Davis, M.D., S. S. French, M.D., and M. A. Garcia, M.D., Battle Creek; O. C. Lyon, M.D., Teconsha; E. C. Collins, M.D., and H. L. Joy, M.D., Marshall. Of these, Dr. J. H. Montgomery was a charter member of the first Calhoun County Medical Society organized in 1839 some thirty-seven years before, also Drs. Cox, Tomlinson, Foote, French, Crosby, Stoddard and Joy.

In 1870, a minute book was established which has been in the possession of various persons during the years. It contains discussions and reports, admissions of new members, many of the arguments and some most interesting papers on topics of the day such as public health, infectious diseases, and included disciplinary measures. That book is now in safe keeping at the Willard Library in Battle Creek. It was maintained until the reorganization of the Calhoun County and the Michigan State Medical Societies in 1902, the period in which most of the medical societies reorganized into more or less modern form. Calhoun County was so prepared that it obtained Charter Number 1 from the reorganized Michigan State Medical Society, Charter Number 2 going to Wayne County.

Health City

Very early, Battle Creek became known as the Health City. An institution had been started on Main Street, known as the "Health Reform Institute," in

1866. About 1874, Dr. John Harvey Kellogg came to Battle Creek as its director. He immediately became interested in all sorts of health items to improve the condition of his patients and patrons. He introduced baths, massage, exercises, bicycle riding and swimming. He gradually developed his Institute into the original Battle Creek Sanitarium, building new and elaborate structures.

At an early stage in his career, he became convinced that meats were not healthful, began devising substitutes, and established a factory to produce his various items. He was against coffee and tobacco, and he became the spark plug of a great industry which developed in Battle Creek, manufacturing the Battle Creek Sanitarium special vegetarian foods. Dr. Kellogg stimulated the establishment of a completely new industry in "prepared foods."

C. W. Post, who was a patient at Dr. Kellogg's institution, studied his plans and programs. Soon afterward, he began experimenting on a substitute for coffee and a substitute for breakfast foods, making them more palatable and acceptable. He established Postum Cereal and the Postum Company which grew into General Foods, whose main manufacturing plant is in Battle Creek. Later, Dr. Kellogg's brother, William K. Kellogg, worked in his sanitarium and manufacturing establishment, helping with food preparations and inventions. He also branched out for himself in the breakfast food field and established on a very small scale, at first, the great Kellogg Company whose headquarters plant is in Battle Creek, with branch plants scattered throughout the world. Breakfast food and food companies became very popular and, during the years, it was reported that there had been in Battle Creek 280 various food companies, including several which Dr. Kellogg had established. There are four mammonth plants in Battle Creek now: General Foods, the Kellogg Company, the Ralston Purina Company and the Battle Creek Food Company, the latter developing and manufacturing the various foods which Dr. Kellogg promoted, including substitutes for meat and coffee.

The Sanitarium itself grew into a world-wide institution, with a capacity for 2,000 patients and thirty physicians. According to a report in the first forty-four years of operation the Sanitarium had 143,643 patients, of which 26,245 were surgical.

Special Hospitals

During the years, special hospitals have been established at various places in the world which added to reputation, prosperity, and the facilities to care for patients. Battle Creek has been unusually fortunate in this regard. First came the Battle Creek Sanitarium, still operating in reduced form as the Battle Creek Health Center. In the late 1890's, Dr. O. S. Phelps returned to Battle Creek and established the "Phelps Sanatorium" in competition with Dr. Kellogg's Sanitarium. A five-story, solid fieldstone masonry building was constructed and operated for a while, but without the anticipated success. Dr. Phelps was competing with the master salesmanship and showmanship of Dr. Kellogg, and also the very unique, full vegetarian diet plus world fame.

Immediately after the First World War, it became necessary to provide hospital services for thousands of World War veterans. The American Legion Hospital was established, using the Camp Custer Recreation Center just outside of Battle Creek. It was a wooden structure, using small buildings from Camp Custer for extension from 120 to 450 beds. That hospital operated for many years, receiving tuberculous veterans, and later took tuberculosis cases from the metropolitan areas in Detroit. Patients increased to several hundreds, all in a single-story structure with corridors connecting. General Foch, Supreme Commander of the Military Forces in the First World War, and General Pershing, came to dedicate that hospital as the "American Legion Hospital."

A little later, Veterans Administration Hospital Number 100 was developed on new grounds which were a part of the Fort Custer site, a modern, up-to-date construction, with a capacity now of around 2,000 neurologic cases. That institution is still going strong.

At the very start of the Second World War, the Army bought and took over the Battle Creek Sanitarium main buildings which had just added a fifteen-story luxury annex. The private rooms were cleared out, wards built, and Percy Jones Hospital became a matter of fact. This was the headquarters for amputees of all types during the war. Wheel chairs were common, and the city built ramps at the curbs which these patients frequented. Percy Jones was closed after the war, then reopened during the Korean war, continued for some time until it was closed again.

The Battle Creek area is a site for still another hospital. During the First World War, an extension was built at Camp Custer, the Camp Hospital, in the northwest section of the area which became Fort Custer in the Second World War. Michigan had accumulated many hundreds of people whom the courts had ordered sent into institutions, but there was no place for them. The suggestion was finally

made that this camp hospital might be used. The abandoned hospital was rejuvenated and made inhabitable for the delinquent children who are housed there now.

Another hospital in Battle Creek was Nichols Memorial Hospital. This started out as a small "union home" in 1889. It had various locations until Mr. John Nichols decided to establish a modern hospital. He purchased an old residence, remodeled it, consolidated it with the union home and changed the name. The hospital underwent various changes, regulations, handicaps, and ultimately developed into a 100-bed hospital. It developed a training school for nurses where the girls spent three years, donated their time mostly, and were taught by various members of the staff. Nichols Memorial Hospital, renamed the Community Hospital, later moved to new quarters in a new location. The Battle Creek Community Hospital is operating on the fifth floor, one of the most modern and complete intensive care units.

Mrs. Leila Y. Post Montgomery, widow of C. W. Post, founder of Postum Company and General Foods, chose the Sisters of Mercy to operate, and built a very modern 100-bed hospital which was opened in 1927. A few years later, when pressured for room, she built an addition of around sixty beds. Soon after opening, Leila Hospital established a nurses training course with ten students in 1928 and forty-nine students in 1929. There was a director of nurses with a superintendent directing the training. The doctors on the staff were the lecturers and the instructors. For many years, the hospital has been cooperating with Mercy College in Detroit. The hospital is now undergoing modernization to include a complete new unit for laundry and other facilities and an extension of the surgical equipment to include special care.

Nursing

For many years, hospitals have been used as training schools for nurses, and most larger hospitals went through that process. The old Nichols Hospital, now Community Hospital, had a training school for nurses for a number of years. This school graduated its first class in the late 1890's and was one of the first training schools. The Battle Creek Sanitarium also conducted such a school for a great many years. The training became more complicated, the registered nurse program more prominent, and many of these nursing schools became attached to University Medical Centers; the others gradually disappeared. The Mercy Sisters established a college in Detroit to care for their nurses, many years before the Battle Creek Sanitarium had done the same thing. There had been a Battle Creek College for years but it moved away, and Dr. Kellogg consolidated his Nursing School and his School of Physical Education into another Battle Creek College, establishing the necessary literary and scientific courses. The college continued for quite a number of years but closed when the Sanitarium itself suffered financial difficulties just before the Second World War. Several years ago, a proposal was made to establish schools for practical nurses and nurses' assistants. The Battle Creek Public Schools have had such a course, proceeding successfully for the past ten years or so.

In all this activity, Battle Creek doctors have been very active in other areas, such as scientific advancement. The research work and training developed at the Battle Creek Sanitarium under Paul Roth, M.D., developed a program, tests and use, pioneering the establishment of basal metabolism. Many of the programs of physical medicine developed at this institution are now being used throughout the world.

State Society Officers

The Calhoun County Medical Society has always had members who attained more than local prominence. In 1879, Edward Cox, M.D., was President of the Michigan State Medical Society, followed in 1888 by S. S. French, M.D., and in 1899 by A. W. Alvoord, M.D., who was also on the State Board of Registration in Medicine. Then there was a long skip until 1930 when Ray C. Stone, M.D., was elected President; in 1949, Wilfrid Haughey, M.D., was named President-for-a-Day, and in 1957, George W. Slagle, M.D., served a term as President. Five of these men served a term and one received the honor. W. H. Haughey, Sr., M.D., served as Delegate, Councillor and as Secretary of The Council for ten years. In 1910, Wilfrid Haughey, M.D., became Secretary and Editor, the two jobs being combined at that time. He served three years and then returned as Editor in 1942.

Blue Shield

The Calhoun County Medical Society can also claim pioneering work in developing Blue Shield and also Blue Cross. Several committees were working about 1931, meeting frequently to consider what a pre-paid health program should contain and should provide. In 1934, members were ready to put a plan in operation, but were prevented by AMA discouragement. In 1936-1937, they were again ready but were prevented on the basis of conflicting with the insurance laws.

Further study was continued by the Council of the State Medical Society with the addition of workers from Washtenaw and Wayne Counties, and Michigan Medical Service was developed very much on the outline which Calhoun County had previously presented.

Drs. R. C. Winslow, Joseph Rosenfeld, Harry Becker, Harvey Hansen and Wilfrid Haughey constituted the various committees that worked during the years and ultimately developed a program. (For details, see a report published in THE JOURNAL of the Michigan State Medical Society, "With Firm and Regular Step," pages 632-661, June, 1951.) Michigan Blue Shield started out as a "wild dream" of a small group, who believed some type of prepaid plan could be developed in spite of AMA opposition, and insurance experts' claims that this was "uninsurable." The plan started with $10,000 borrowed from the Michigan State Medical Society, and it is now paying out $7,500,000 a month; $82,000,000 in the current year. Calhoun County is and should be justly proud of its many ventures and accomplishments.

Heart Disease Cure Still Complex

Heart disease is as old as Adam, but finding a cure is dishearteningly complex, a University of Michigan medical expert believes.

Charles J. Tupper, M.D., assistant dean of the University of Michigan Medical School and associate professor of internal medicine, says the human heart works in a way that expresses Nature's menace, marvel, mystery, all in one:

The American heart is considerably more susceptible than the Japanese heart, for example. National death rates caused by heart disorders: United States—705; Japan—90 (per 100,000).

Heart disease is America's greatest killer of man; more than half a million Americans die of it every year.

Physically, the heart muscle contracts and relaxes alternately and continuously, pumping the blood steadily through the lungs and body. Inside the cells of heart muscle tissue, certain chemical changes go on which give the heart the energy to work. Finally, electrical impulses trigger and stimulate the rhythmic contraction and relaxation of the heart.

One of the most important chapters of the heart research story is the study of these electrical impulses, Dr. Tupper says. Since the turn of the century, a crude method of measuring the electrical stimulus to the heart beat has been developed into today's electrocardiogram. It determines specific cause of some types of heart disease. The most recent great innovator of the electrocardiogram is the late Frank N. Wilson, M.D., former University of Michigan professor of internal medicine. Today, it is one of the most important weapons used in the war against heart disease.

Actually, there are more than 20 well-defined types of heart disease. But the most serious types fall into two large classifications:

About 10 per cent of all heart disease, common among children, is caused by the leakage or obstruction of the heart's valves which prevents the normal passage of blood. The exact cause is not known, but it is associated with rheumatic fever and follows streptococcus infection of the throat. The best cure is prevention and prompt treatment of the infection.

Most of the remaining 90 per cent is made up of diseases affecting arterial flow of blood to body tissues and to the heart's own "feeding-system." It is most common among adults between the ages of 30 and 60 years.

The tiny arteries that feed the tissues throughout the body become narrower and less elastic. Then the pressure rises because the heart has to pump harder to force blood through the small arteries. Although the exact cause is far from completely understood, tension, stress, anxiety, and diet may be responsible. At the moment, the best shield against this menace may be preventive education, University of Michigan doctors suggest.

"The answer to the menace of heart disease will one day be found by medical science. The work will be accomplished, as always, by 'the seekers'—that army of stubborn and skillful researchers who play the 'waiting game' with death," Dr. Tupper concludes.

Thrombotest—A New Method for the Control Of Oral Anticoagulant Medication

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THE INCREASING use of oral anticoagulants in recent years for myocardial infarction and other thrombo-embolic conditions has intensified the search for a more reliable method than the time-honored Quick's prothrombin time to guide the medication. The risk of bleeding still keeps many clinicians from using oral anticoagulants on a long-term basis after coronary occlusion.

In the search for more dependable control of anticoagulant medication, a number of new methods have been developed, but some of them are too time-consuming and are mainly used in research. The so-called P&P method, developed by P. A. Owren, has been in use for the control of anticoagulant medication in the Scandinavian countries for the past ten years, and has been shown to be superior to Quick's method.[1,2] Recently, however, Owren has developed a new method for the control of anticoagulant medication, called the Thrombotest. This test seems to be superior to any presently used method, both because of its simplicity and its physiological approach to the coagulation mechanism involved during anticoagulant medication.

Before going any further in discussing this method, I would like to summarize briefly the present concept of the coagulation of the blood and the factors involved. There are presently twelve known factors involved in the coagulation process (Table I). Thrombin is the key substance in the coagulation process. It is not normally present in the circulating blood. It is derived from the inactive plasma precursor prothrombin. Prothrombin is converted to thrombin by a principle which probably is an enzyme, prothrombinase. Once prothrombinase is formed, the blood clots in a few seconds.

There are reasons to believe that prothrombinase may be developed in two different, partly independent, ways which are often referred to as the intrinsic and extrinsic blood clotting systems. Figure 1 and Figure 2 illustrate this concept. The extrinsic system needs the presence of one clotting factor not found in the circulating blood, namely — tissue thromboplastin; hence, the term extrinsic.

The following factors are known to take part in the formation of extrinsic prothrombinase: tissue thromboplastin, proconvertin, calcium ions, proaccelerin and Stuart-Prower factor.

TABLE I. NUMBER OF CLOTTING FACTORS WITH MOST FREQUENTLY USED SYNONYMOUS DESIGNATIONS

Factor Number	*Synonyms*
Factor I	Fibrinogen
Factor II	Prothrombin
Factor III	Tissue thromboplastin
Factor IV	Calcium
Factor V	Proaccelerin
	Labile factor
(Factor VI)	(Accelerin)
Factor VII	Proconvertin
	Stable factor
Factor VIII	Antihemophilic A factor
	Antihemophilic factor (AHF)
	Antihemophilic globulin (AHG)
Factor IX	Antihemophilic B factor
	Plasma thromboplastin component (PTC)
	Christmas factor
Factor X	Stuart-Prower factor
	Stuart factor
Factor ? (not numbered)	Antihemophilic C factor
	Plasma thromboplastin antecedent (PTA)
Factor ? (not numbered)	Hageman factor

In the formation of intrinsic prothrombinase, the following factors take part: Hageman factor, antihemophiliac factors A, B and C, calcium ions, Stuart-Prower factor, proaccelerin, and a lipid-containing factor in the blood platelets.

The two coagulation systems seem to differ in importance in physiological hemostasis. Patients with different forms of bleeding tendencies will illustrate this. Hemophiliacs, whose intrinsic clotting system is very defective, but whose extrinsic system is normal, have a severe bleeding tendency. Patients with congenital proconvertin deficiency, however, have usually a mild hemorrhagic diathesis, with little tendency to spontaneous hemorrhages. However, they often bleed freely after surgery, trauma, tooth extraction, et cetera. In these patients, the extrinsic system is impaired, whereas the intrinsic system is normal.

We shall now turn back to the methods used for determination of oral anticoagulants (dicumarol and phenylindandione derivatives). These anticoagulants cause a reduction of antihemophilic B factor of the intrinsic system, proconvertin of the extrinsic system, and prothrombin and Stuart-Prower factor which take part in both systems.

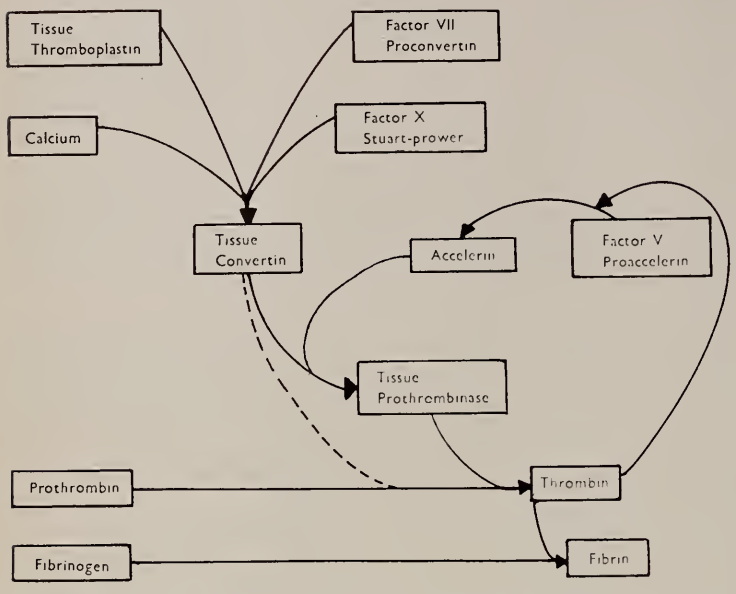


Fig. 1. Clotting theory of Owren: extrinsic system. The possible influence of contact and other factors on proconvertin has been disregarded.

Owren's P&P method was designed to measure the deficiency of prothrombin and proconvertin, which were thought to be the two main clotting factors affected by anticoagulant medication. Quick's prothrombin time method has complete absence of sensitivity to variations in antihemophilic B factor, and the P&P method is only slightly sensitive to variations in this factor (Fig. 3). The sensitivity to proconvertin is also minimal with Quick's method, but normal with the P&P method (Fig. 4). Thus, it is evident that both these methods are inadequate in the control of anticoagulant medication where these factors are involved.

Thrombotest was developed with the purpose of a balanced measurement of all the factors involved during oral anticoagulant medication. The method is sensitive to all the factors involved both in the intrinsic and extrinsic system. The intrinsic system, which acts slower than the extrinsic system, has been accelerated through the introduction of an active cephalin preparation, while the extrinsic system has been retarded through the introduction of thromboplastin with low activity.

For simplicity, an "all-in-one-reagent" has been devised, which contains the cephalin, the thromboplastin, calcium and a substrate-plasma with a high content of all clotting factors not influenced by the anticoagulant treatment. The plasma has been freed of the four factors to be determined. When the patient's blood or plasma is added to the reagent, the clotting time will depend only on the concentration of these four factors in the blood.

The reagent is lyophilized and kept in vacuum-sealed ampoules. It is reconstituted with distilled water for the testing of capillary blood, and a 3.2 mM calcium chloride solution for testing of citrated blood or plasma.

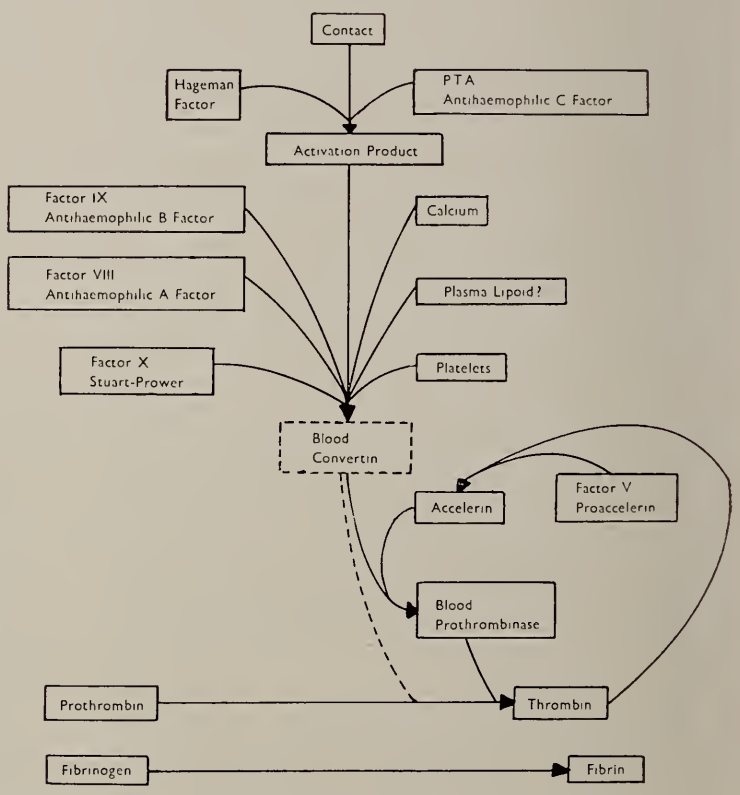


Fig. 2. Clotting theory of Owren: instrinsic system.

Capillary Method.—0.5 ml of the reconstituted reagent is measured into a small test tube, leaving it in a water bath at 37° C. for not less than 3 minutes to reach the correct temperature, but not more than

30 minutes. Capillary blood 0.10 ml is then added and the coagulation time measured. The coagulation time is converted to coagulation activity, expressed in percentage of the normal, with the aid of a correlation curve. (Standard curves are made for each bath and supplied together with the dried reagent. Normal controls are unnecessary).

Venous Blood Method.—Nine volumes of blood are mixed with one volume of 3.13 per cent (W/v) sodium citrate dihydrate. The lyophilized reagent is

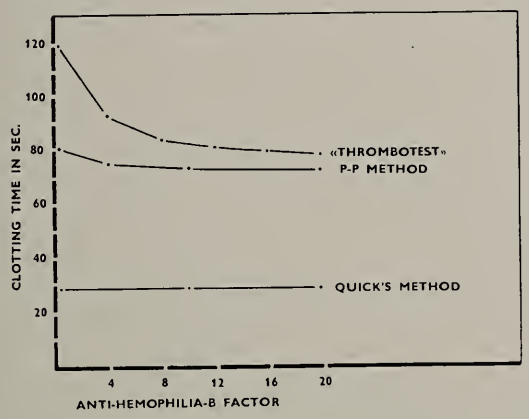


Fig. 3. Sensitivity to Factor IX (PTC, Christmas factor, antihemophilia B factor). Plasma from a patient with hemophilia B was mixed with normal plasma in various proportions. The mixtures were assayed in three test systems after dilution 1 + 4 with adsorbed human plasma in order to imitate conditions during anticoagulant therapy. (Conc. of prothrombin, Factor VII (Proconvertin) and Stuart-Prower factor about 20 per cent in all samples tested). (After Owren).

dissolved in the calcium chloride solution according to instructions. Otherwise, the procedure is identical with the capillary method.

Plasma Method.—Citrated blood is centrifuged, and a measured volume of plasma is diluted with normal saline in the proportion 3 plus 2. The plasma and reagent is then utilized as with the previous methods.

Owren recommends plastic or siliconized tubes for the collection of the blood in the last two methods. If the blood is stored in a glass tube, activation processes will start with shortening of the coagulation time. This phenomenon is seen both with Quick's method, the P&P method, and the Thrombotest method. However, if the test is done within an hour after the blood is drawn, the influence of glass tubes is negligible in patients on oral anticoagulants.

The so-called therapeutic range for anticoagulant therapy as controlled by this method is considered to be 10 to 25 per cent of normal, which also is the range recommended by many clinicians using Quick's method.

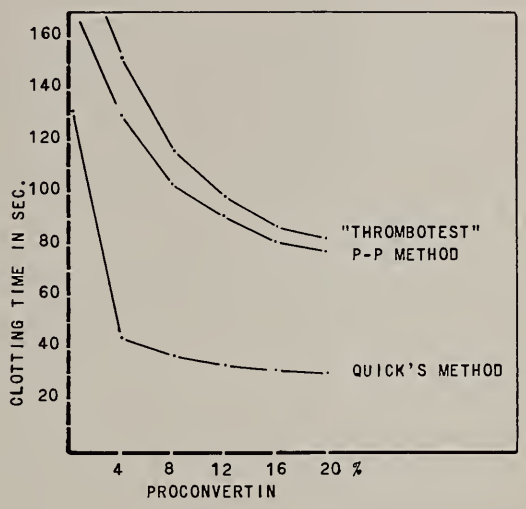


Fig. 4. Sensitivity to Factor VII (Proconvertin). Plasma from a patient with congenital deficiency of Factor VII was mixed with normal plasma in various proportions. (After Owren).

The normal clotting time with Thrombotest is about 36 to 40 seconds, slightly higher with venous blood than capillary blood. Clotting time for blood samples during anticoagulant therapy in the therapeutic range of 25 to 10 per cent vary from about 70 seconds to 160 seconds. A technical error of a few seconds in reading will not cause a large deviation in the calculated percentage activity (Fig. 5). This is in contrast to Quick's method, where a few seconds' difference in reading makes a marked difference in percentage activity.

Own Material.—The Thrombotest method using venous blood was tried in seventy-two patients at Battle Creek Community Hospital and in the author's office laboratory. Almost all these patients were on anticoagulant medication, mainly dicumarol or warfarin. The method of venous blood was chosen because most of the patients were in bed and the blood had to be collected on the ward and brought to the laboratory. This excluded the use of the capillary method. In all patients, Quick's prothrombin time determination was also performed for comparison. The results of both methods are plotted on the graph (Fig. 6). Both Quick's method and the Thrombotest were performed by the same laboratory technician at the hospital, where most of the determinations were done. Considering that the technicians were un-

familiar with the Thrombotest method, there is fairly good correlation with Quick's method.

The Thrombotest capillary method was tried in a few patients concurrent with the venous blood method

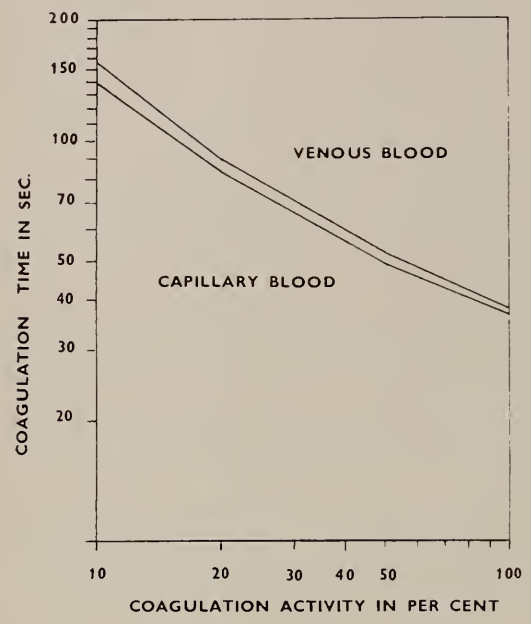


Fig. 5. Correlation curve for converting clotting-times to coagulation activity in percentage of normal. A similar curve is included in every package of Thrombotest material.

and Quick's method and gave quite equivalent results. Tests with the capillary method were too few, however, to warrant any conclusions. This method seems to be very practical in larger outpatient clinics for anticoagulant medications, as only a drop of blood is needed and the result is available in a couple of minutes.

As pointed out by Owren[3] several sources of error have to be watched. When using the capillary method, the first drop of blood should be taken for testing; later drops will give accelerated clotting. A free flow of blood is also important, as pressure or squeezing of the skin to produce enough blood shortens the coagulation time.

Summary

Thrombotest is a method for control of anticoagulant therapy which seems to be superior to present available methods, both in dependability and simplicity. It takes into account all four blood-clotting factors affected by oral anticoagulants (antihemophilic B factor, proconvertin, prothrombin and Stuart-Prower factor).

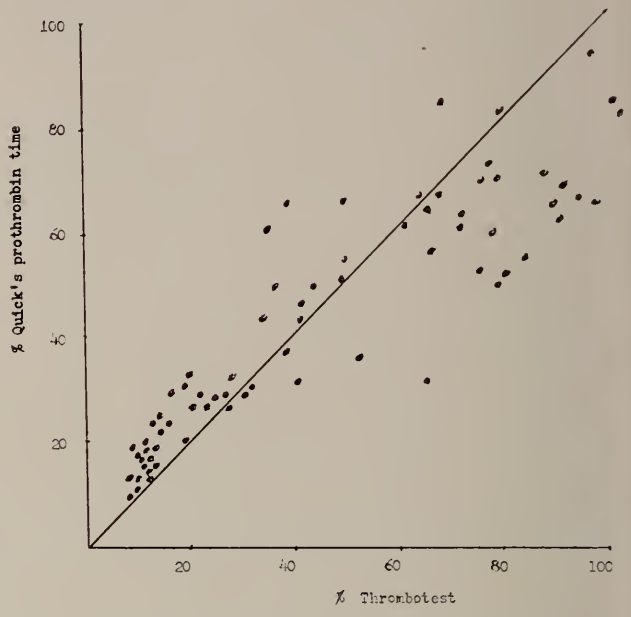


Fig. 6. Coagulation activity in 70 patients. The per cent activity for both the Thrombotest method and Quick's method is plotted for each patient.

The test can be performed on capillary blood or on citrated venous blood or plasma. The capillary method seems to be ideal for outpatient use, as the result is available immediately. The test which presently is being used to a great extent in Scandinavia deserves to be tested in the larger medical centers in the United States.

Acknowledgment

I wish to thank the Pathology Department at Community Hospital for making facilities available for this study, and Miss Ruth Fretz for her valuable assistance.

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Unusual Aspects of Anaphylactoid Purpura In Childhood

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IT IS not the purpose of this paper to review in detail the subject of anaphylactoid purpura ("Schönlein-Henoch syndrome"). Such a review has been adequately presented by Allen, Diamond, and Howell.[1] We are interested rather in calling attention to some of the more serious manifestations and complications of this most interesting disease.

The precise etiology remains uncertain. That it may represent a hypersensitivity reaction has been generally accepted. Such agents as preceding infections, foods, drugs, and environmental chemicals have been implicated as at least being aggravating factors.[2] Freud et al[3] described a case in which the patient developed anaphylactoid purpura and renal failure following vaccination against smallpox. The symptoms and findings are varied. A purpuric rash appearing mostly over bony prominences is essential for the diagnosis, but it may not be evident until after more serious manifestations have appeared, complicating the diagnostic and therapeutic management as will be illustrated in the cases presented herewith. Other symptoms and signs include periarticular swelling, fever, soft tissue edema, bleeding from mucous membranes and, even more distressing, gastro-intestinal disturbances with or without bleeding and renal involvement ranging from transient hematuria to marked impairment of renal function leading to death. Allen et al,[1] in their review referred to above, reported two patients who developed neurologic symptoms with convulsions associated with hypertension, and Lewis and Philpott[3] described three cases, in one of which there were no signs of renal disease.

The pathology of the lesions of anaphylactoid purpura has been described by Kreidberg and associates[4] as consisting of acute perivasculitis in the walls of small vessels. Vernier,[5] by use of skin and kidney biopsy, has found fibrinoid thrombi in capillaries and an associated endothelial perivascular reaction. The renal studies suggested a focal glomerulonephritis as the characteristic lesion.

The gastro-intestinal manifestations may be the most distressing from an emergency life-threatening point of view. Wolfsohn[6] collected nineteen cases from the literature on the complication of intussusception and added one of his own. Allen[1] reported on four and Steinharst and Jonas[7] described yet another case. To these, we are adding one as will be noted later. Exsanguinating hemorrhage, obstruction, and perforation of the bowel[8] are other serious complications of abdominal purpura.

Treatment of these grave aspects depends on the merits of each case. Those showing intussusception or other forms of intestinal obstruction usually need surgical intervention as well as supportive therapy, such as blood transfusions. Exsanguinating hemorrhage must be treated for shock and the blood loss. The question of the place of steroids in the treatment of this condition has not been fully settled. However, the observations of Allen and colleagues[1] warrant serious consideration. They stated, "When the diagnosis of Schönlein-Henoch's purpura of gastro-intestinal involvement is made, we believe that immediate steroid therapy is indicated in an effort to reduce the edematous hemorrhagic areas in the bowel wall and thus possibly prevent the secondary complications of intussusception and massive hemorrhage. This seems particularly true since none of our patients who received adequate steroid treatment of twelve hours or longer developed symptoms of intussusception. We have found that symptomatic improvement in the abdominal pain is a fairly consistent and striking feature and gastro-intestinal hemorrhage, which may be quite massive and life-endangering, is also usually controllable with adequate steroid therapy." With renal involvement, the value of steroids is less certain. The disease has periods of remissions and exacerbations, and since many individuals do recover in spite of severe renal manifestations, it would be difficult to ascribe definite benefit to the use of steroids under such circumstances. For similar reasons it is difficult

to ascribe prognastic value to biopsy studies. Perhaps a long term follow-up will clarify this particular problem.

We shall now describe briefly four illustrative cases from our own experience with equally brief comments on each one.

Case 1.—K. R., a six-year-old white boy, suffered abdominal pain, which became progressively worse over a twenty-four-hour period. This was associated with vomiting on two occasions. The child had a low grade temperature, developed RLQ pain with guarding, had an elevated white count with shift to the left, culminating in an appendectomy. At operation, the appendix was perfectly normal. The following day, swelling developed in the left wrist and, subsequently, a migratory polyarthritis ensued involving wrists, elbows and ankles. Seventy-two hours following admission, the child developed a purpuric rash over the buttocks and lower extremities.

Comment.—This case serves to illustrate the multifacet symptomatology of allergic purpura, without definitive symptoms occurring until after abdominal surgery had already been carried out. It also serves to illustrate that this particular malady must be considered in the differential diagnosis of acute conditions of the abdomen.

Case 2.—R. K., a four-year-old white boy, developed a URI and otitis media which was treated with triple sulfa. One week later, the child developed a macular rash over the lower extremities and buttocks, which subsequently involved the upper extremities. The rash persisted for two weeks, at which time the child developed swelling of his joints. The rash then became purpuric in character, and the child developed microscopic hematuria. All hematological tests gave normal findings. The child was discharged and within one week displayed the typical findings of acute glomerulonephritis with gross hematuria.

Comment.—This case illustrates the probable etiological role of sulfa, the rather extended history of rash prior to joint swelling. It also reveals the usual microscopic hematuria and the not infrequent occurrence of acute glomerulonephritis.

Case 3.—T. M., a child of eight years, had a history of vomiting and abdominal cramps for forty-eight hours. Shortly thereafter this white boy developed swelling of the ankles and wrists and a purpuric rash involving the lower extremities. This was followed by the onset of black tarry stools, and admission to the hospital was instituted. On admission, the urinalysis revealed a 2+ albuminuria and microscopic hematuria. After admission, melena continued unabated, the child having six to seven grossly bloody stools, necessitating three whole blood transfusions to maintain the hemoglobin above 10 Gm. The child was also started on cortisone, and the rectal bleeding subsided in forty-eight hours. However, the microscopic hematuria was replaced by gross hematuria and all the findings consistent with acute glomerulonephritis. The urinalysis did not return to normal for a period of nine months.

Comment.—This is the case of a child with typical Schönlein-Henoch syndrome, who developed massive gastro-intestinal bleeding, which responded rapidly to steroids, and then proceeded to develop an acute glomerulonephritis.

Case 4.—P. R., a two-year-old white girl, developed acute abdominal pain four days following the onset of a purpuric rash of the lower and upper extremities associated with polyarthritis. The abdominal pain was severe and intermittent, and the patient vomited on two occasions. There was no rectal bleeding, but a mass was palpated in the left lower quadrant. A diagnosis of intussusception was made and confirmed with a barium enema. At operation, a bleeding Meckel's diverticulum was found, representing the head of the intussusceptum. The bowel was quite hemorrhagic, thus requiring a bowel resection with the removal of 4 feet of intestine. The child was also given blood and intravenous fluids to combat shock and anemia. The postoperative course was uneventful.

Comment.—This two-year-old child developed an acute intussusception with allergic purpura. This serves to remind one of this diagnosis and not to mistake severe abdominal pain as part and parcel of this malady.

Summary

A review has been presented stressing the more unusual and endangering aspects of anaphylactoid purpura. Comments on management and illustrative cases have also been presented.

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The Use of Oral Hypoglycemic Agents in the Control Of Diabetes Mellitus

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AT PRESENT, three oral agents for the control of hyperglycemia are available to the practicing physician: Tolbutamide (Orinase®) Chlorpropamide (Diabinese®) and Phenformin (DBI®).

Tolbutamide and chlorpropamide are sulfonylurea drugs and are indentical in their mechanism of action, differing in their rate of metabolism and rate of excretion. Phenformin is totally different; it is not a sulfonylurea and differs in its mechanism of action from the sulfonylurea compounds. The mechanism of action of phenformin is not fully known; much has been uncovered as to its role and its mode of action, namely that phenformin causes no changes in glucose tolerance or sensitivity to insulin. There is no change in urinary excretion of nitrogen, potassium, 17-hydroxycorticoids and 17-keto-steroids in diabetics. Phenformin does increase blood pyruvate and lactate levels during glucose tolerance tests. Thus, there is no reason to believe that inhibition of adrenal function, decreased gluconeogenesis from protein and increased insulin activity are the mechanisms of action. There may be some relation to pyruvate disposal, and this suggests that phenformin produces its hypoglycemic effect by causing an increase in anaerobic glycolysis as a result of suppression of cellular oxidation.[1] Clinical evidence does not support an anaerobic mechanism for the action of phenformin and a more recent hypothesis[2] suggests that at physiologic concentrations phenformin increases the oxidation of glucose in hepatic tissue and possibly adipose tissue via the hexose monophosphate shunt, but at present there is no single hypothesis explaining the hypoglycemic mechanism of action of phenformin.[2]

Pharmacologically, there is no determinable effect other than hypoglycemia. No organ toxicity has been reported in any patient to date,[3] and this includes hepatic, hematologic, renal, thyroid or cardiac. The side effects encountered in the use of phenformin are related to dosage, rate of increment of dosage. The side effects most frequently encountered include anorexia, headache, nausea, vomiting, diarrhea, drowsiness and vertigo.[4] The incidence of side reactions varies considerably with various reports. Initially, with the use of phenformin, attempts to achieve hypoglycemic response were approached with too much vigor, and this resulted in a greater incidence of gastrointestinal side reactions. The incidence of side effects can be greatly reduced or avoided by the judicious use of the drug, the rate at which the dosage is increased, and patient individualization. The dictum of "start low, go slow" is to be followed. The patients who do well and tolerate the drug with full therapeutic range will be started on a dosage not to exceed 50 milligrams per day. The rate of increment should not be less than three to four days, even a full week, and then only with 25 milligram increments. The time of administration is very important. Taking the dosage just prior to, with, or following the meal will result in abolishment or great reduction of the gastrointestinal side effects which are central rather than local in origin.[5]

The use of phenformin in early clinical trials met with a greater incidence of failure because the above principles were not followed. Phenformin is a very valuable drug in the control of diabetes mellitus and can be used alone or in combination with insulin or one of the sulfonylurea compounds. Phenformin is unique in that it can be used in all types of diabetes, and all types studied have responded to treatment with phenformin.[6] The drug phenformin is most effective in the stable-maturity onset, keto-acidosis resistant type of diabetic patient. The drug should be used with insulin in the labile, brittle type of diabetic patient and has no place in the treatment of diabetic coma.

The effectiveness of combined oral therapy of phenformin and sulfonylurea compounds in keto-acidosis resistant diabetes, in patients who have failed on sulfonylurea compounds alone, has been achieved in as high as 70 per cent and in 60 per cent of diabetics who were uncontrolled on phenformin alone.[7] Beaser achieved satisfactory lowering of blood sugar in nineteen out of twenty-five patients who failed to respond to the sulfonylurea compounds alone.[8] This

becomes of utmost importance because of the reported toxicity of sulfonylurea drugs, and the rate of 2 per cent secondary failures in any one month with use of tolbutamide.[9] Primary failures as well as secondary failures to the sulfonylurea drugs should be tried on this combination therapy.

There is no problem of hypoglycemic reaction with the use of phenformin alone.[10] The sulfonylurea drugs are practically impotent in total diabetes; that is, the growth onset or the severe adult labile, brittle diabetic patient. The use of phenformin on the other hand is of great value in the management in this type of case.[11] The reduction of the required insulin dosage and the avoidance of serious side effects of hypoglycemic reaction has been achieved in the labile diabetic patient with the use of combined therapy of insulin and phenformin. The breaking of insulin resistance has been achieved with dramatic results in some instances.[12-13]

White, in treating juvenile diabetic patients with the combination of insulin and phenformin, was able to reduce insulin dosage and avoid serious, severe hypoglycemic episodes and maintain adequate growth.[14] The use of phenformin and insulin affords the physician a tool to smooth the course of management in the labile diabetic patient and avoid the hazardous episodes of hypoglycemia.[15]

The current indications for phenformin can be broken down into classes.[5]

I. DBI.
Alone
Stable, maturity onset, keto-acidosis resistant diabetes.

II. DBI.
Alone or plus sulfonylureas
primary and secondary
Sulfonylurea failures.

III. DBI.
Usually with insulin.
Labile growth onset diabetes.

Forty cases were selected from clinical office practice for this series. The age range was from twelve through eighty-seven. The majority of patients were between forty and seventy-nine, numbering thirty-three cases. DBI was used alone in twenty-five of the cases, DBI in combination with insulin in fourteen cases, and DBI with sulfonylurea drug in one case. The dosage range in the patients treated with DBI alone was 50 to 150 mgm/Da; average dosage 75 mgm, maximum dosage 150 mgm, minimum dosage 25 mgm. The dosage range, when combined with insulin, was 50 to 100 mgm/Da; average dosage 75 mgm, minimum dosage 50 mgm/Da.

Incidence of Side Reaction

In only two cases of the entire series was the drug discontinued because of inability to tolerate the drug, manifested by nausea, vomiting, and diarrhea, an incidence of 5 per cent.

Degree of Control

Satisfactory control was achieved if the blood sugar fasting remained under 170 mgm per cent, weight was maintained and hypoglycemic episodes were kept at a very severe minimum. This was achieved in twenty-three out of twenty-five of those treated with DBI alone. In the group of DBI plus insulin, satisfactory control was achieved in ten out of fourteen. In the four cases considered unsatisfactory, reduction of insulin dosage was achieved on the average of 18 units of insulin, and avoidance of severe hypoglycemic reactions was achieved. The entire group, in which insulin plus DBI was the therapy, were of the labile brittle type of diabetic patients who were very difficult to manage prior to the institution of DBI.

The one patient, in whom DBI and sulfonylurea were used, was a case of secondary sulfonylurea failure in whom excellent control was achieved by the combination therapy. Satisfactory control was achieved in thirty-four of forty patients (85 per cent). The longer the duration of diabetes, the more difficult it was to achieve satisfactory control. The series pointed up that those responding best were patients having recently discovered diabetes, over the age of forty, with no previous therapy. Duration of therapy ranged from two months to twenty-seven months.

Summary and Conclusions

The use of phenformin alone or in combination with insulin and sulfonylurea compounds in forty cases has been evaluated. Excellent control was achieved in 85 per cent of the cases, and in only two cases (5 per cent) was the drug discontinued because of undesirable side effects. In one of these, satisfactory blood sugar levels were maintained. Phenformin is safe and the oral hypoglycemic agent of choice because of absence of toxicity and wide range of activity in all types of diabetes. Recently, phenformin (DBI) has been released in the form of a time-disintegrating capsule, which should reduce even more the unpleasant gastrointestinal side effects.

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Forces Joined in Campaign Against Quackery

The American Medical Association and the federal government have declared all-out war on medical quacks and charlatans who bilk the sick and gullible of hundreds of millions of dollars each year through useless gadgets, phony nostrums, fake reducing pills and the many other gimmicks of the medicine show trade.

The campaign was launched at the recent First National Congress on Medical Quackery, under joint sponsorship of the AMA and the U. S. Food and Drug Administration in Washington. Keynote speakers were Secretary of Health, Education and Welfare Abraham A. Ribicoff and Postmaster General J. Edward Day. Leonard W. Larson, M.D., president of the AMA, and Oliver Field, director of the AMA Department of Investigation, spoke for organized medicine.

Doctor Larson declared:

"We must educate the public thoroughly and effectively. We must wage psychological as well as scientific warfare. We must not only prove the worthlessness of quackery, but we also must establish confidence in sound medical and health care. Speaking for the American Medical Association and our 180,000 physician-members, I pledge our efforts to the final eradication of quackery and all its minions and satraps."

Secretary Ribicoff stated:

"The total cost of unnecessary or dangerous medications in this country probably exceeds $1 billion each year. Much of this expense is to men, women, and children who dearly need this money for good medical care or for other necessities of life.

"But quackery's cost in dollars only introduces the story. In terms of false hopes raised, in terms of ugly delusions fostered, in terms of tinkering with human life itself, the cost cannot be measured. The quack flirts with disaster. He challenges the sixth Commandment: 'Thou shalt not kill.' "

Postmaster Day stressed:

"The peddling of fake medical cures is the most prominent fraudulent activity conducted through the U. S. mails today. This huge 'industry'—and it has grown to that extent —is so prevalent and so widespread that it taxes the manpower of the Postal Inspection Service to the utmost in trying to bring the perpetrators to justice. We are doing everything we can to make more of our inspectors available to work on cases of this nature, to the extent it will not jeopardize enforcement in other fields."

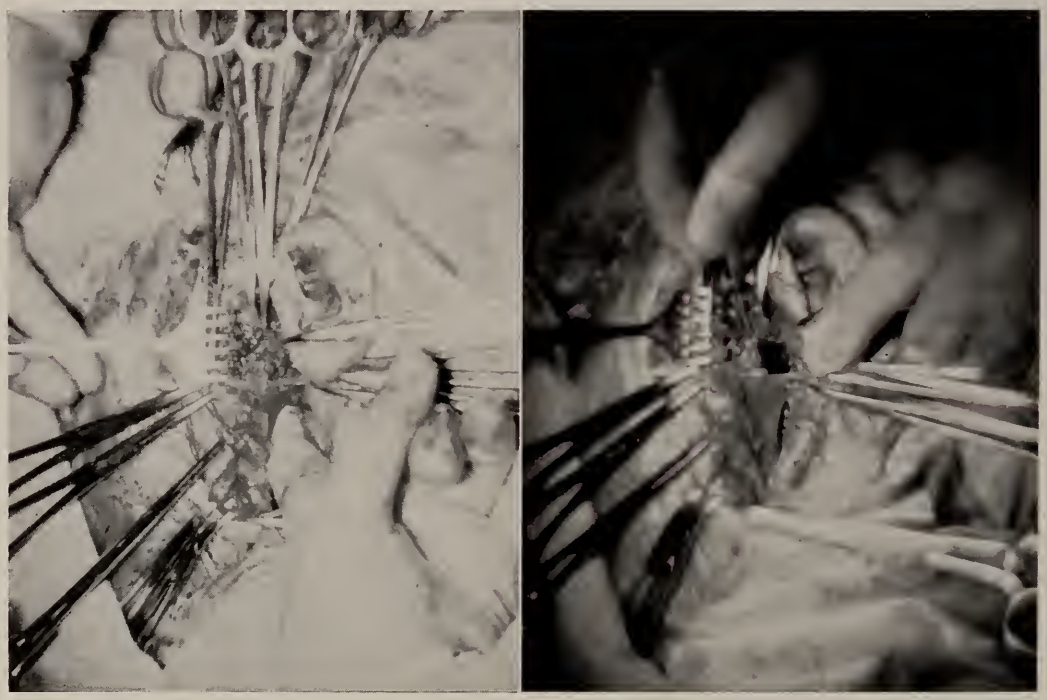
Mixed Tumor of the Parotid Gland Appearing As a Pharyngeal Mass

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IN THE evaluation of a mass in the lateral pharynx, tumors originating in the parotid gland must be considered, and, of these, the benign mixed tumor is the most common.

The anatomical relations of the parotid gland are such that a developing tumor arising in the gland may appear as a mass in the lateral aspect of the pharynx. There is a deep extension of the gland lying posterior to the mandible, and anterior and inferior to the external auditory meatus. This extension is frequently referred to as the pharyngeal prolongation, and may be intimately related to the lateral pharyngeal wall. The main trunk of the facial nerve, anterior to the stylo-mastoid foramen, may lie within this prolongation, with the bulk of the parotid tissue below it, or surrounding it. The relationships of the external carotid artery within the gland anteriorly, and the internal carotid artery entering the temporal bone posteriorly, are also of surgical significance.

The presenting symptoms from such a lesion are usually a feeling of fullness in the throat with some difficulty in swallowing. The onset is exceedingly slow, with a duration extending as much as ten years. Paralysis of the facial nerve is almost never seen in benign lesions of the parotid, and if present should immediately suggest a malignant neoplasm.



Figs. 1 and 2. The external approach illustrating the exposure of the facial nerve and delivery of the tumor inward with a finger below the nerve (*left*). The opening above the nerve (*right*) likewise extends into the pharynx.

These tumors present problems primarily by occupation of space, and removal is indicated to prevent the difficulties of dysphagia, and eventually obstruction of the airway as well as the food passage. In

general, when the diagnosis is made, the tumor should be removed, for delay with growth to a greater size will only render the procedure more difficult.

As with any benign mixed tumor of the parotid, the goal is complete removal of the lesion with preservation of the facial nerve. Awareness of the anatomical relations will immediately demonstrate that removal with a wide margin of normal tissue is impossible.

The approach will frequently require intra-oral and external incisions. Exposure of the facial nerve with subsequent careful preservation of this structure is possible only with the external approach, and the modified Blair incision has long seemed the most satisfactory.

The accompanying illustrations demonstrate the removal of such a lesion. The intra-oral incision was made from the lateral aspect of the soft palate through the left tonsillar fossa. The mass lying on the prevertibral fascia extended downwards from the base of the skull and laterally around the styloid process, indicating intimate association with the facial nerve.

The mass was quite easily freed from surrounding structures by blunt dissection on all surfaces, except the lateral. An external approach through a modified Blair incision allowed careful dissection of the mass from the facial nerve. The tumor was then delivered through the pharyngeal incision with external assistance. The external wound was closed with a drain, and healed nicely. The incision in the throat was not closed, and healed in much the same manner and course as a tonsillar fossa following tonsillectomy.

The final photograph illustrates perfect function of the muscles innervated by the seventh nerve.



Fig. 3. The intra-oral incision one week following the operation.



Fig. 4. The dumbell-shaped tumor with the lateral mass removed and sectioned.



Fig. 5. Perfect function of the facial nerve and a nicely healed scar two weeks following the operation.

Home Care Programs

In 1960, some 30 cities had 45 coordinated home care programs, caring for approximately 5,000 patients. These programs attempt to furnish medical, nursing, social, and rehabilitative services to selected patients in their own homes. These patients generally do not require all the treatment facilities of a hospital and are too ill or otherwise unable to visit a physician's office or an outpatient clinic.

The Use of Retroperitoneal 100 Per Cent CO_2 in Urology

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FOR MANY years, a satisfactory method of retroperitoneal insufflation has been needed. The past method of using pure oxygen or nitrogen has been unsuccessful. Nitrogen and oxygen both can result in air embolism. Deaths from this cause have been reported in both instances. In addition to air embolism occurring instantaneously in the usage of retroperitoneal oxygen and nitrogen, delayed complications also are of consequence. The patient who is injected with oxygen or air will frequently retain the gas in the retroperitoneal space, the mediastinum or the subcutaneum for up to ten days, and carries this constant potential danger with him. The patient must be watched very carefully for signs of shock, respiratory distress and symptoms of the bends. In contrast to this, CO_2 retroperitoneal insufflation is advantageous. The carbon dioxide in the retroperitoneal space is totally absorbed within thirty to forty minutes. In normal usage, radiographs must be taken before five or ten minutes have elapsed, or an inadequate picture will result due to rapid absorption. Where delayed radiographs have been taken, we have been unable to demonstrate CO_2 remaining beyond an hour, consequently we have had no difficulty in regard to delayed complications of CO_2 insufflation. In addition, the danger of embolism is minimal since CO_2 can be readily injected into the blood stream where it is absorbed with sufficient rapidity that air embolism does not occur. Intravascular injection of CO_2 is employed in some centers to make cardiac ventriculograms. We are therefore not worried about the possibility of embolism with CO_2.

Indications

Adrenal lesions can often be demonstrated with CO_2 insufflation. Pheochromocytoma, large carcinomas and cysts are well seen. Smaller lesions such as small adenomas or carcinomas may not be demonstrable. Hyperplasia may or may not show up well. The larger the lesion, the more easily it is demonstrated. Hyperplasia of 10 grams and over can be seen. In one specific instance, the size of the adrenals as measured by retroperitoneal CO_2 insufflation very accurately represented their actual size.

The main indication in renal pathology is the desire to see the renal outline, such as seen in renal cysts, neoplasms and duplication anomalies. If cystic congenitally separate upper pole is suspected, retroperitoneal CO_2 will frequently demonstrate this lesion. In selected cases where it is desirable to localize the renal outline accurately, retroperitoneal CO_2 is ideal. It should here be used only as an adjunct to pyelography. A tumor deformity found on an intravenous pyelogram, or retrogrades when an adequate shadow is not seen, can be readily further delineated by CO_2 and combined intravenous pyelogram or retrograde studies. In addition, the precise size of the tumor is seen, and this assists the operator in deciding upon his approach, whether through the flank or thoracoabdominal or Nagamatsu. We have made no effort to use this study as a means of determining whether tumors are solid or cystic.

One of the most useful areas in which this study has been used is in determining the presence or absence of retroperitoneal masses. In many instances, the splenic shadow is read as a retroperitoneal mass, and this is readily demonstrable by retroperitoneal CO_2 insufflation as not being present in the retroperitoneal area.

In the investigation of hypertension, CO_2 is sometimes indicated to assess renal size accurately. It can be done at the time of retrogrades during the Howard test without much added risk.

It is also worthy of note that in any instance where retroperitoneal fibrosis or retroperitoneal inflammations, such as perinephritis, has occurred, the CO_2 study tends to be of little value, since the gas does not diffuse through fibrotic or inflamed tissues. The study has also been of no use in delineating any ureteral lesions.

Materials

The equipment required for retroperitoneal CO_2 is minimal. CO_2 in 100 per cent concentration can be purchased. It is to be noted that frequently CO_2 cylinders supplied are not 100 per cent CO_2 but the 5 per cent CO_2 used in anesthesia, and this must be watched since 5 per cent CO_2 is not desirable for insufflation. On the CO_2 cylinder, 2 meters are desirable, one pressure gauge, which indicates the

amount of pressure remaining in the cylinder, and the other, a flow meter such that the flow rate can be measured and the amount of CO_2 calculated by timing the injection. This apparatus can be purchased from most instrument houses, particularly those that handle anesthesia equipment. A straight ¼ inch rubber tubing, approximately 5 or 6 feet long, is led from the flow meter to a three-way stop cock which is tied to the end of this tubing with umbilical tape. The three-way stop cock is useful since the flow can be temporarily diverted if the patient has pain. In addition, the stop cock allows one to test for the patency of the line. The three-way stop cock also fits nicely into the Rochester needle.

A Rochester needle* is a composite needle consisting of an ordinary 16-gauge tapered pointed needle, over which is placed a piece of plastic tubing which is affixed to a Luer lock attachment such that the 16-gauge needle may be withdrawn, leaving a plastic tube and Luer lock attachment in place. The technique of introducing the Rochester needle is explained elsewhere. After the apparatus is in place, the pressure gauge is turned on and the flow meter set at 1 liter per minute. This is timed for 60 seconds, the patients thereby receiving 1 liter of retroperitoneal CO_2.

Method

Patients in whom retroperitoneal CO_2 insufflation is contemplated are normally prepared as for intravenous pyelogram, and in many instances pyelography is concomittant to CO_2 insufflation. They are given 1 ounce of castor oil the evening before. A cleansing enema is administered the evening before, and the patient is fasting from midnight of the evening before. In addition to preparation for an intravenous pyelogram, it has been our custom to administer routine preoperative sedation one hour previous to the hour of CO_2 injection. Demerol in 100 mgs. has proved very satisfactory. The patient is not usually given a general anesthesia, although insufflation, of course, can be carried out this way. It has been our experience that having the patient awake and cooperating is of more use and less difficulty than having the patient anesthetized. The discomfort that arises from retroperitoneal CO_2 insufflation is usually minimal, Demerol sedation in these cases being adequate. Usually, patients complain of crampy abdominal discomfort and this indicates that the CO_2 is going retroperitoneally. Severe abdominal pain may indicate that there is excess CO_2 in the retroperitoneal space and some dissection of the mesentery is occurring, in which case the procedure is terminated and the radiographs are taken. A scout radiograph of the abdomen is taken initially to determine technique and to determine the fecal gas pattern, to see whether the insufflation can be accomplished and interpreted. Excessive gas and feces in the intestinal tract indicate postponement of the procedure until better preparation is available. Once the technique of radiography has been determined by scout radiograph of the abdomen, the patient can be placed in the knee-chest position or, more preferably, in the lithotomy position. The genitalia and perianal area are prepared and, with a finger in the rectum, a one centimeter skin wheal is raised with a local anesthetic between the anal margin and the coccyx. Allowing a minute or two for this to take effect, a Rochester needle is inserted into the retrorectal space, and the palpating finger can readily determine when the plane between the coccyx and rectum has been entered. Care should be taken to avoid penetration of the rectum; this can readily be accomplished by having a finger in the rectum. Once the needle is in place, the rectal finger is withdrawn, and the steel center of the Rochester needle is removed, leaving the plastic coating *in situ*. The Luer lock attachment on the Rochester needle is then inserted into the three-way stop cock, which is opened.

Complications

Initial reactions include severe abdominal pain. This is most likely to happen when the needle has entered the rectum and the colon is being distended by gas. Severe pain can also occur if excessive amounts of CO_2 are injected and the mesentery is dissected. Severe pain is an indication to stop the procedure and take a radiograph. In most of these cases, the procedure can be continued if the radiographs are inadequate, since the pain rapidly subsides.

Respiratory distress may be seen as acute dyspnea and a choking sensation. This is usually due to mediastinal CO_2, and tipping the patient head down will encourage dissolution and absorption of CO_2. Occasionally, the patient's blood pressure falls in this instance. The head-down position also assists venous return. No persisting shock has been seen.

Subcutaneous CO_2 has been seen in the neck due to excessive injections. If the emphysema appears in the buttocks or thighs or scrotum and perineum, the needle has been misplaced. The subcutaneous CO_2 is rapidly absorbed.

No fatalities have occurred in twenty cases.

*Rochester Instrument Mfg., Co., Rochester, Minn.

The Use of Bisacodyl (Dulcolax) in Preparation For Barium Enema Examination

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THOROUGH cleansing of the large bowel with minimal patient discomfort is desirable as a preliminary to proper roentgenologic examination of the lower intestinal tract, urinary tract and spine. For many years, the standard preparation for such procedures has included castor oil. Recent reports[1-4] have indicated that a new drug (Bisacodyl) can adequately cleanse the colon with significantly less patient discomfort than occurs with castor oil. Accordingly, a comparative evaluation of castor oil and bisacodyl with regard to both effectiveness and patient subjective response was undertaken at The University of Michigan Health Service.

TABLE I.
AGE AND SEX DISTRIBUTION—140 PATIENTS

Age	Male	Female
20-29	5	5
30-39	47	3
40-49	42	1
50-59	22	3
60-69	4	3
70-89	4	1
Total	124	16

The group of patients examined in this series differs from those in previous reports.[1-4] Of the 140 patients examined, 134 were members of The University of Michigan faculty undergoing a periodic health appraisal which included roentgenologic examination of the gastrointestinal tract. The details of this study have been reported elsewhere.[5,6] It should be recognized that these patients represent an essentially asymptomatic group of apparently healthy individuals. The remaining six patients were students.

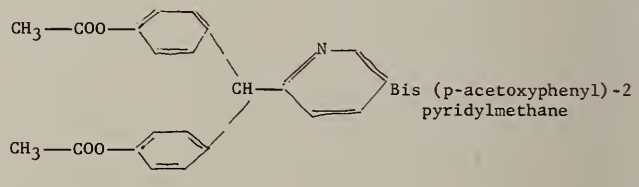
Most of the patients were male and all were seen on an out-patient basis. The ages range from thirty to eighty-eight years. The exact age and sex are outlined in Table I. In general, it can be assumed that the group of patients examined is one of high intelligence, with good ability to follow instructions and to cooperate. Instructions to the patient were thoroughly carried out without exception, and subjective information obtained from patients was considered to be highly reliable.



The Author
C. J. TUPPER, M.D.

Chemistry and Pharmacology

Bisacodyl, known commercially as Dulcolax, is a synthetic compound which is insoluble in water or alkaline solution but soluble in dilute mineral acids and organic solvents. It has no taste, odor or color and is one of a group of contact laxatives made up of Bis (p-acetoxyphenyl)-2 pyridylmethane. It is said to be the most active of this group of compounds due to the presence of a nitrogen atom in the alpha position on the pyridine ring.[2]



Pharmacologically, the compound acts primarily upon the mucosa of the large bowel with increase in peristaltic activity. It is a contact laxative and is not dependent on systemic absorption. Fortsch[7] demonstrated that it is not present in the milk of nursing mothers. Other experimental work has indicated that it acts neurogenically by selective stimulation of the

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Part of the bisacodyl (Dulcolax-TM) used in this series was supplied by Geigy Pharmaceuticals, Yonkers, N. Y.

parasympathetic nerve supply of the colon.[2] Going and Schaumann[8] demonstrated abolition of effectiveness of Dulcolax suppositories by the use of topical anesthesia of the mucosa of the rectum and the sigmoid.

TABLE II. AGE AND SEX DISTRIBUTION BY METHOD OF PREPARATION

Age	Group I		Group II		Group III	
	Castor Oil		Bisacodyl—10 mg. (o) at h.s., 10 mg. Suppository h.s. and a.m.		Bisacodyl—15 mg. (o) at h.s., 10 mg. Suppository a.m.	
	Male	Female	Male	Female	Male	Female
20-29	2	4	0	0	3	1
30-39	17	0	7	0	23	3
40-49	22	1	7	0	13	0
50-59	12	1	5	2	5	0
60-69	1	2	1	0	2	1
70-79	0	1	2	0	2	0
Sub-total	54	9	22	2	48	5
Total	63		24		53	

The therapeutic index of bisacodyl is 1:200[2] and no toxicity has, to our knowledge, been reported. The product is supplied in 5 mg. enteric coated tablets and 10 mg. suppositories.

In contrast, castor oil is an irritant which acts primarily on the small bowel and often leaves residual oil droplets in the colon which must be distinguished from polyps.

Methods

Three different methods of preparation were used. On the day preceding the examination all patients had a light noon meal, and supper consisted of a pure liquid diet, omitting milk. None of the patients had anything to eat or drink on the morning of the examination. The patients in Group I were given 2 ounces of castor oil at 5:00 p.m. on the evening preceding the examination. Cleansing enemas were not used. The patients in Group II were given 10 milligrams of bisacodyl orally at 10:00 p.m. on the evening before the examination. In addition, these patients used one 10 mg. bisacodyl suppository at the same time. On the morning of examination, two hours before the scheduled barium enema, an additional 10 mg. suppository was used. The patients in Group III were given a 15 mg. oral dose of bisacodyl at 10:00 p.m., and the evening suppository was omitted. They, too, used a 10 mg. suppository two hours before the x-ray examination.

The radiologist was not informed in advance of the examination as to the type of preparation used by the patient, and patients were advised not to divulge such information to the examiner. Notations were made at the time of the barium enema procedure as to effectiveness of the cathartic, tonicity of the colon, and any evidence of irritative phenomena during the fluoroscopic examination.

Pre-evacuation radiographs were posterior-anterior projections. Exposure factors were: 100 kv. and 200 ma. The post-evacuation films were exposed at 90 kv. and 200 ma. The barium enema mixture contained a 1 per cent solution of tannic acid.

Within a few days after the barium enema examination, the patients were interviewed as to their personal evaluation of the preparation used, the time of onset of evacuation, loss of sleep, abdominal cramps, or other adverse effect. Those patients who had previously had a barium enema examination with castor oil preparation and who were given bisacodyl on this occasion were asked for a subjective comparison of the two methods of preparation.

At the time of radiograph interpretation, the examining radiologist was asked to state his impression as to the effectiveness of the large bowel preparation. Three categories were used:

1. E: Excellent (either complete absence of any residual fecal material, fluid and gas, or virtually none of these residua.)
2. G: Good (Minimal residual feces, fluid, or gas, but not of sufficient magnitude to interfere with good diagnostic quality.)
3. P: Poor (excessive amount of residual feces or fluid resulting in inconclusive results and the need for repeat examination.)

The objective opinion of another radiologist was then obtained. The pre-evacuation radiographs of all patients were assessed by him and categorized in the previously described fashion. Three separate readings, without knowledge of the type of preparation used, were made at approximately one-week intervals. Finally, the same set of pre-evacuation radiographs was interpreted again by the original examining radiolo-

gist. In this manner, five separate opinions were obtained on each case. The final tabulated impression as to the effectiveness of preparation thus represents the majority of five separate readings.

4 a.m. and 6 a.m., but more often closer to six and one-half hours following oral administration of the tablets. These patients, as in Group II, had few complaints about the method of preparation. The morning suppository was effective in twenty-six of the fifty-three cases, or about 50 per cent. The examination was well tolerated, and the large bowel rarely showed evidence of increased irritability at the time of examination. The few patients who had the experience of having had castor oil at one time and bisacodyl at another were unanimously in favor of the bisacodyl preparation. No nausea, urticaria or other side reactions were encountered in the Group II and III patients.

TABLE III. COMPARISON OF BOWEL PREPARATION WITH CASTOR OIL AND BISACODYL

Preparation	Total Patients	Evaluation		
		Excellent	Good	Poor
Group I Castor oil	63	22 34.9%	32 50.8%	9 14.3%
Group II Bisacodyl (10 mg. + 2 suppositories)	24	9 37.5%	11 45.8%	4 16.7%
Group III Bisacodyl (15 mg. + 1 suppository)	53	23 43.4%	26 49.1%	4 7.5%

Results

The Group I patients who had been given castor oil experienced more discomfort with the praparation than Groups II and III. All of these subjects objected to the taste and odor of castor oil. Many complained of cramps, rectal and perianal irritation, and were tired and disgruntled on arrival at the x-ray department, due to sleeplessness and discomfort during the preceding night. Repeat examinations, necessary because of poor preparation, were refused by three patients in this group, all of whom gave castor oil preparation as the cause for their refusal. At the time of examination, the castor oil group displayed more apprehension and showed evidence of persistently increased colon irritability with localized, generalized colon contractions which sometimes resulted in inability to retain the enema long enough for adequate fluoroscopy and radiographing.

The Group II patients had fewer complaints about the preparation. The evening suppository resulted in a formed stool in approximately twenty to sixty minutes. None of the patients complained of loss of sleep. The tablets were ingested at 10 p.m., and most patients had their first bowel movement between 4 a.m. and 6 a.m. The morning suppository, given two hours before the examination, resulted in additional passage of feces and fluid in eighteen of the twenty-four patients, but had little or no effect in the remaining six patients. During the barium enema procedure, the colons of these patients did not appear to be as irritable as had been the case in the Group I (castor oil) patients. The procedure was better tolerated, and none of these patients objected to repeat examinations.

The Group III patients showed results superior to Groups I and II in effectiveness of cleansing of the large bowel. The first evacuations occurred between

On a statistical basis, there was no significant difference in the cathartic effect in the three groups of patients, (Chi-square 2.1969; degrees of freedom, 4; p, approximately .70). Similarly, Group I with castor oil preparation was compared with Group III as the superior bisacodyl preparation. Again, there was no statistically significant difference between these groups, (Chi-square 1.7154; degrees of freedom, 2; $.40 < p < .50$).

Discussion.—Although there was not a significant statistical difference in the cathartic quality of castor oil, as compared with bisacodyl, there is a great difference in the subjective response of the patient. It is our opinion, on the basis of this comparative study and on the basis of many discussions with the patients on the merit of various preparations, that the use of bisacodyl in a dose of 15 mg. orally at 10 p.m., and 10 mg. as a suppository two hours before the examination is the method of choice, and this is now the standard method of preparation at the University Health Service.

Summary

One hundred and forty patients were prepared for barium enema examination with either castor oil or

bisacodyl. The cleansing effectiveness of the two methods of preparation was compared and no statistically significant difference between the methods of preparation was apparent. The patient's subjective response was overwhelmingly in favor of bisacodyl preparation and, for this reason, we consider it to be the method of choice.

Acknowledgment

The authors appreciate the assistance in statistical evaluation given by Dr. Richard D. Remington, of the University of Michigan School of Public Health.

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Ask Doctors Help in Study of Insect Stings Allergy

The American Academy of Allergy is seeking the help of doctors of medicine in a study of the history and treatment of allergic reactors to insect stings.

The request for Michigan participation was presented to The MSMS Council, which sought an opinion from the MSMS Legal Counsel. In part, the opinion said:

"Since compliance with this request would require that the individual physician disclose information acquired by him in the treatment of his patient, I am of the opinion that, for the complete protection of the individual physician, the consent of the patient to the release of the information should be obtained.

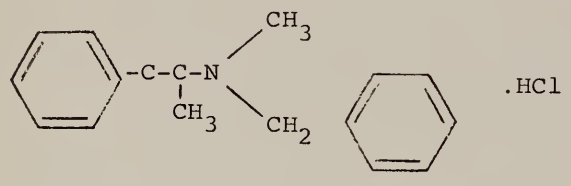
"As you know, the laws of Michigan are quite specific on the matter of disclosure of information regarding a patient and are even more strict than that of many other states. In our state, disclosure of confidential information about a patient is not only made a ground for revocation of license under the Practice Act but is also, under a separate statute, grounds for criminal prosecution."

The American Academy of Allergy study is conducted by volunteer physician members of The Academy without cost to the patient. Cooperating patients will be sent a wallet-size card to alert medical personnel to the possibility that a sudden severe illness might be caused by insect sting allergy. The Academy will take the names from the doctors and mail each a questionnaire to be filled out by the patient. A follow-up annual inquiry of the patient will be made as to whether he has been stung during the year, by what type of insect, if known, and with what results. Some of these patients will have had no immunization for stinging insects, some will have had a few immunizing doses and some may be treated with a long term course of hyposensitization. By comparing the subsequent sting history of persons in these various catagories, the Academy hopes to learn the most desirable therapeutic course to follow.

Reduction in Body Weight and Blood Pressure Following Administration of Benzphetamine Hydrochloride (Didrex®)

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MODELL[1] recently noted that the sympathomimetic effects of amphetamines on the cardiovascular system may be more developed in some members of the group than others. These effects may include a rise in blood pressure, increase in cardiac work and heart rate or the development of arrhythmias. Since the anorexiant drug, benzphetamine hydrochloride*, with the following structural formula, is clearly an amphetamine congener, it seemed important to see if dosages sufficient to induce appetite suppression would have significant effects on blood pressure, pulse rate or cardiac rhythm.



In our earlier study[2] of 24 men given benzphetamine tablets, 50 mg., and 25 given matching dummy ones, three times daily for 28 days, single blood pressure determinations done before and after the test period did not seem to be changed in either group. Mean pre-drug pressure was 138.0/96.3. After 150 mg. of benzphetamine daily for 28 days, mean pressure was 135.8/97.1 mm. Hg. In the control group of men the corresponding mean values were 136.3/91.4 and 129.4/94.8 mm. Hg. Thus insignificant reductions in systolic values, and elevations in diastolic pressures were observed in both drug and placebo groups.

In an effort to study this matter in greater detail the present investigation was carried out.

Materials and Methods

Twenty adult male subjects with hypertension (systolic pressure of 150 mm. Hg. or more, diastolic pressure of 90 mm. Hg. or more, or both) were studied. Fourteen were consistently hypertensive. The remaining six had blood pressure elevation on repeated occasions but not every day (Subjects 10, 12, 15, 17, 18, 20). Prior to drug administration, blood pressure determinations with the same sphygmomanometer were done on each man morning and afternoon daily for 23 days. The morning blood pressures were taken as early as possible, preferably before breakfast, but at the same time for each individual. Each man rested for two minutes in a chair prior to the taking of his blood pressure in the standing position. Body weight and height were recorded. Baseline blood urea nitrogen values, complete blood counts and urinalyses for albumin were obtained.

After this control period all men were given one 50 mg. tablet of benzphetamine three times daily, before meals, for 30 days. (The medication was rebottled by us and dispensed as "blood pressure medicine." No hint was given that it was expected to have an effect on appetite.) Morning and afternoon blood pressure determinations were continued in exactly the same way. Urine specimens were examined weekly.

All men were interviewed individually and daily the first week of drug administration and then approximately three times weekly during the test period. Leading questions concerning appetite or diet were avoided.

At the end of the 30-day test, twice-daily blood pressure readings were continued for six additional days to establish mean post-treatment levels. Body weights, blood urea nitrogen values, urinalyses and complete blood counts were repeated. A brief final interview was done to assess the over-all opinion of effectiveness of the drug with particular reference to blood pressure and side effects.

Results

Weight Change.—Following the 23-day control interval, during which no significant weight changes were noted, every man lost some weight during the 30-day treatment period, as may be seen in Table I. Aggregate loss was 132.00 pounds, with a mean plus or minus standard error of 6.60 ± 1.03 pounds. The

*The Upjohn Company trade name for benzphetamine hydrochloride is Didrex®.

TABLE I. COMPOSITION OF STUDY GROUP, WEIGHT AND BLOOD PRESSURE CHANGES NOTED

No.	Race	Age	Height	Pre Rx Wt.	Excess Wt.[1]	Wt. Lost	Pre Rx B.P.[2]	Post Rx B.P.[3]	Change B.P.
1	N	47	5-8 ½	188.00	+21.00	− 9.00	196.3/152.2	162.0/137.3	−34.3/−14.9
2	N	36	5-11	190.25	+16.25	− 8.25	134.3/110.3	132.0/101.0	− 2.3/− 9.3
3	W	39	5-10 ½	260.50	+88.50	−17.00	129.0/112.0	128.0/105.0	− 1.0/− 7.0
4	N	68	5-9 ¾	238.50	+66.50	− 7.00	174.0/121.3	164.3/125.7	− 9.7/+ 4.4
5	W	27	5-6	223.75	+75.75	−17.50	135.7/ 98.0	141.7/ 91.3	+ 6.0/− 7.7
6	W	64	5-7	177.00	+18.00	− 7.00	170.0/112.3	143.0/102.3	−27.0/−10.0
7	W	57	5-6	189.50	+32.50	− 2.00	151.3/105.0	150.0/103.7	− 1.3/− 1.3
8	N	42	5-10 ½	193.50	+17.50	− 4.50	117.7/ 93.3	113.7/ 88.3	− 4.0/− 5.0
9	W	41	5-8	176.25	+11.25	− 4.50	136.0/113.3	128.3/107.3	− 7.7/− 6.0
10	W	59	5-7 ½	186.25	+22.25	− 4.50	113.7/ 86.0	104.0/ 80.0	− 9.7/− 6.0
11	W	37	5-9 ¼	169.00	+ 2.00	− 6.50	136.0/ 97.0	129.7/ 94.7	− 6.3/− 2.3
12	W	60	5-3 ¼	142.50	− 0.50	− 6.00	140.7/ 85.0	119.0/ 80.7	−21.7/− 4.3
13	N	46	5-8 ¼	157.75	− 8.25	− 8.25	172.0/150.7	155.3/133.0	−16.7/−17.7
14	N	65	5-3 ¾	144.50	− 0.50	− 5.00	173.3/101.0	154.0/ 95.3	−19.3/− 5.7
15	N	37	5-7 ¾	142.25	−17.75	− 1.75	125.7/ 89.3	120.3/ 82.7	− 5.4/− 6.6
16	N	58	5-8	162.25	− 3.75	− 4.25	132.0/107.2	128.7/102.7	− 3.3/− 4.5
17	W	38	5-2	131.00	− 6.00	− 5.25	118.0/ 89.7	119.3/ 98.7	+ 1.3/− 1.0
18	W	24	5-8 ¾	146.25	− 5.75	− 1.25	115.7/ 87.8	107.0/ 82.7	− 8.7/− 5.1
19	N	53	5-7 ¼	162.50	− 0.50	− 2.50	147.7/104.7	138.3/101.3	− 9.4/− 3.4
20	W	33	5-10 ¼	159.50	−11.50	−10.00	126.0/ 86.0	118.7/ 86.0	− 7.3/0

[1]Based on Society of Actuaries' 1959 Tables.
[2]Mean blood pressure final six days of 23-day control period, morning readings.
Six-day mean values (A.M.) following cessation of drug administration.

men who were overweight 11 or more pounds (Subjects 1-10) prior to drug administration lost an average of 8.13 pounds. But even Subjects 11-20, who were not obese, lost an average of 5.08 pounds. And this occurred during 30 days without limitation on dietary intake.

Cardiovascular Aspects.—In order to increase "n" for statistical purposes, 46 control blood pressure values were obtained on each subject prior to benzphetamine, 60 during the test period, and 12 were recorded after administration was stopped. (See Table II.) The only striking and significant alteration in blood pressure was reduction in mean systolic values in the post-treatment determinations. This was true of the morning data whether compared with the entire 23-morning experience or the six-day pretreatment values. The reduction in mean afternoon systolic pressure was significant when compared to the 23-day control average, but not when the six-day pretreatment value was used. Overlapping of these six diastolic confidence intervals clearly showed no difference between these six means at the five per cent significance level.

Alterations in pulse rate or regularity, as noted when blood pressures were taken, were not observed.

Side Effects.—Impaired appetite, noted by all subjects to some degree, was reflected by weight loss. Interference with sleep was the rule the first night or two but thereafter all slept except one. He complained of some difficulty getting to sleep throughout. Dryness of the mouth was reported by 11 men, increased salivation by one, mood elevation by five, increased sweating and dizziness each by four. Increased urinary frequency was noted by two men, hesitancy by another. Two reported decreased libido, one an increase. Four observed increased sweating, two others, a decrease. Nausea, possibly

TABLE II. MEAN BLOOD PRESSURE VALUES, MORNING AND AFTERNOON, FOR 20 MEN AT DIFFERENT INTERVALS OF THE STUDY

Time Done	Period	Pressure Component	"n" Observations	Mean (mm. Hg.)	Standard Error	95% Confidence Limits
A.M.	23-day control period	Systolic	460	143.07	±1.08	140.95—145.19
		Diastolic	460	102.73	±0.82	101.12—104.34
A.M.	Final 6 control days	Systolic	120	142.25	±2.18	137.98—146.52
		Diastolic	120	104.65	±1.71	101.30—108.00
A.M.	First 6 days on drug	Systolic	120	136.65	±2.03	132.67—140.63
		Diastolic	120	104.33	±1.61	101.17—107.49
A.M.	First 6 days *after* drug stopped	Systolic	120	132.85	±1.78	129.36—136.34
		Diastolic	120	99.56	±1.48	96.66—102.46
P.M.	23-day control period	Systolic	460	142.91	±1.09	140.77—145.05
		Diastolic	460	101.91	±0.77	100.40—103.42
P.M.	Final 6 control days	Systolic	120	141.07	±2.17	136.82—145.32
		Diastolic	120	102.44	±1.52	99.46—105.42
P.M.	First 6 days on drug	Systolic	120	137.50	±1.90	133.78—141.22
		Diastolic	120	104.53	±1.53	101.54—107.52
P.M.	First 6 days *after* drug stopped	Systolic	120	135.20	±1.83	136.61—138.79
		Diastolic	120	99.02	±1.33	96.41—101.63

drug related, occurred in three instances and one man vomited. Loose stools and flatulence were each reported once. Several noted increased energy. Two said the pills made them relaxed and "lazy."

Blood urea nitrogen values at the end of 30 days' drug administration were unchanged from the controls. Urinalyses and complete blood counts, all negative prior to the trial, were still within normal limits.

Discussion

The findings in this study confirmed those of Rhoades,[3] Poindexter[4] and Stough.[5] Systolic blood pressure may be significantly lowered in hypertensive patients given benzphetamine. The design of the experiment was such that the effect of novelty, unfamiliar procedures and so on, was largely ruled out by repetition prior to drug administration. A slight fall in both morning and afternoon systolic levels was observed during this control period. And at the end of the 30-day drug trial, significant further weight loss and blood pressure reduction had occurred. (There was no correlation between the number of pounds lost and the lowering of blood pressure.) From the practical standpoint of management of the obese hypertensive patient, it does not matter whether reduction in blood pressure is due to the anorexiant drug *per se*, or to loss of body fat. Lowering of body weight and blood pressure are both to his advantage.

It was noteworthy in this series, selected on the basis of hypertension rather than obesity, that the ten men who were not overweight lost from 1.25 to 10 pounds during drug administration. This apparently reflected the anorexiant effect of benzphetamine, an effect independent of the initial weight status of patients given the drug.

The side effects noted during the first few days and nights of treatment were similar to those we reported earlier[2] and which have been noted by others[3-5] giving 150 mg. of benzphetamine daily. This dosage is probably excessive, and certainly unnecessary, at least at the beginning of administration for the management of obesity. In many instances a good anorexiant effect may be obtained with 50 or even 25 mg. of benzphetamine once daily.[6]

Summary

Following a 23-day control period, during which blood pressure determinations were made twice daily on each of 20 hypertensive men, 50 mg. tablets of benzphetamine hydrochloride (Didrex®) were given thrice daily before meals for 30 days. Blood pressures were recorded twice daily during this test period and for six days after the drug was discontinued. Analysis showed a significant weight loss averaging 6.60 $\pm$ 1.03 pounds. All 20 men lost weight, including 10 who were not initially overweight. Eighteen men had a decrease in systolic blood pressure. The average reduction in the 20 subjects was 9.40 $\pm$ 2.39 mm. Hg., also significant at the five per cent level. Diastolic levels were unchanged at the conclusion of the 30-day study.

In discussion it was pointed out that this did not support the thesis that benzphetamine was a hypotensive agent. Rather, it suggested that the reduction in body mass was reflected by lowering of systolic pressure. From the practical standpoint of management of the obese hypertensive patient, it did not matter whether reduction in blood pressure was due to the anorexiant drug *per se*, or to loss of body fat. Lowering of body weight and blood pressure would both be to his advantage.

It would seem from the experience reported here that benzphetamine is a safe, effective adjunct in the weight reduction program of the obese patient with hypertension.

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Leiomyoma of Tunica Dartos Scroti

A *Case Report*

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LEIOMYOMA of the tunica dartos scroti, not to be confused with leiomyoma of the testicular tunics, is a rare lesion. In 1937, Stout,[1] in a review of the world literature, was able to find three cases of leiomyoma of the dartos. We have been able to find no further cases and are adding a fourth case of leiomyoma of the dartos muscle.

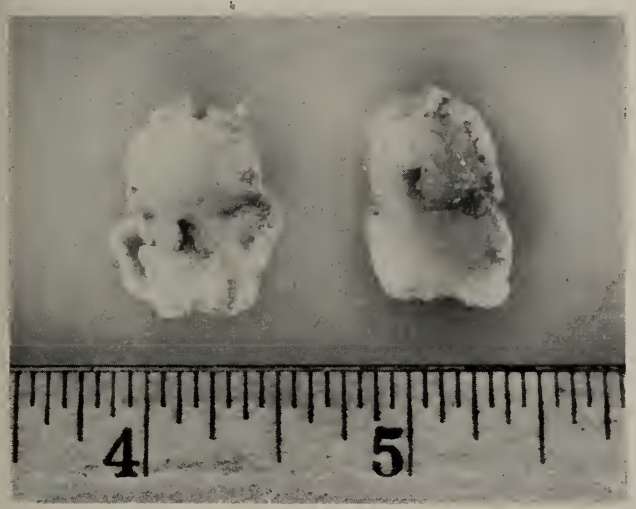


Fig. 1. Leiomyoma of dartos muscle. The tumor is whitish.

Case Report

W. W., a thirteen-month-old white male child, had a history of fulness in the left inguinal region of six months' duration. The fulness was evident on crying or straining. In addition, there was a mass present in the scrotum of ten month's duration which varied in size. Two months prior to admission, the mass in the scrotum became firmer according to the parents. The remainder of the history was non-contributory.

Physical Examination.—Examination of the patient was negative except for the inguinal region and scrotum. There was a globular mass in the inguinal region associated with the spermatic cord. The mass was one centimeter in diameter and reduced in size on manual pressure. The separate mass was located in the dependent portion of the left scrotum and was firm, smooth and not tender. The mass measured three by two centimeters and was not attached to the underlying testicle but caused some indentation of the overlying skin.

Laboratory Data.—The urinalysis revealed no abnormalities. The hematological studies revealed a hypochromic microcytic anemia of 9.5 grams, and a leukocytosis of 12,300.

Operative Findings.—Exploration through a left transverse inguinal incision revealed an indirect inguinal hernia and communicating hydrocele of the spermatic cord. These were repaired and excised, and the wound closed in layers. A separate hard mass was palpated in the left wall of the scrotum which was not attached to the testis. The tumor attached to the scrotal skin caused dimpling of the skin. The tumor and overlying skin was completely excised, a drain was inserted, and the wound closed.

Pathology.—Gross examination of the specimen revealed a whitish nodular mass that measured 1 x 5 x 2 centimeters (Fig. 1). Histologically, the tumor was composed of interlacing bundles of mature smooth muscle merging into islands of spindle cells which show mucoid degeneration of the cytoplasm (Fig. 2). There was some collagenous fibrous tissue between the smooth muscle. There were no mitotic figures or evidence of anaplasia in the smooth muscle. The tumor was diagnosed as a leiomyoma.

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Discussion

There has been much confusion in the literature as to leiomyomata in the scrotal area. Hinman and Gibson[5] state that tumors of the testicular tunics are difficult to distinguish from those arising in adjacent structures. They further propose that they may be

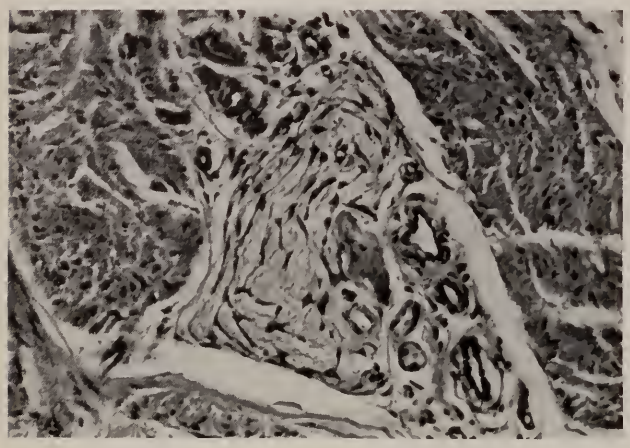


Fig. 2. Leiomyoma of dartos muscle. Note the well-differentiated smooth muscle cells. H & E X 90.

derived from the smooth muscle fibers of the cremasteric internus of the tunica vaginalis communis. Thompson[6] states that these may actually arise from the gubernaculum.

Being true peritoneum, the tunica vaginalis contains no smooth muscle; however, one can postulate that leiomyomas may arise from this tissue due to misplaced or ectopic mesodermal elements.

Some mention must be made of the adenomatoid tumors of the epididymis. Longo, McDonald and Thompson[7] reported that these tumors always have smooth muscle elements, and, at times, may be void of adenomatous tissue and appear as a pure leiomyoma. These, however, are located in the epididymis and must not be confused with leiomyoma of the tunica dartos. This lesion is in the wall of the scrotum and is not attached to the epididymis or testicular tunics.

Summary

A case of leiomyoma of the tunica dartos scroti has been presented and the literature reviewed.

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Rheumatoid Arthritis

Evidence that there is some association between unexpressed hostility and rheumatoid arthritis is fairly substantial, a University of Michigan researcher explained at a pre-convention meeting of mental health and psychiatric nurses, held in Ann Arbor in November.

Dr. Sidney Cobb, epidemiologist and a program director for the University of Michigan Survey Research Center, said not all cases of rheumatoid arthritis follow this behavior pattern—since it is suspected that heredity, infection and trauma (injury and shock) may be important factors in some cases.

He mentioned two types of home environment in which the nurses might look for psychosomatic manifestations, some of which he described in case histories.

The first situation is mutual, unexpressed hostility in which tension can be felt in the air.

"This situation is self-propagating and probably contributes to headache, backache, rheumatoid arthritis, divorce and delinquency," Dr. Cobb said.

"The second thing to watch for is the mixture of hostility and dependency in the same individual or the same family. One might expect that a hostile individual would find it more difficult to get his dependency needs met and might therefore be more susceptible to duodenal ulcer."

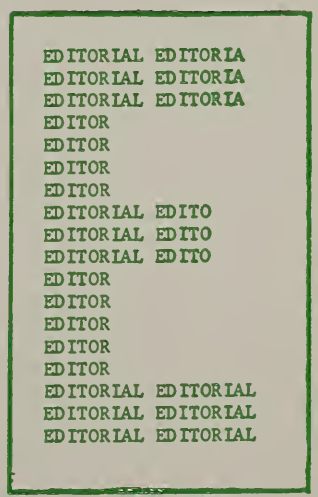
Nineteen Sixty-one

With this December number of THE JOURNAL, we bid farewell to the year 1961 with a feeling of satisfaction and belief that the medical profession has again written its mark upon medical history. THE JOURNAL, in its original articles, in its committee reports, in its registering of activities, functions and programs, has recorded many new things. Our scientific accomplishments have been portrayed in part by 150 original published articles from 172 authors. We know scientific value, accomplishment, and a recording of our progressively increasing knowledge has been well worth while and will rank in intrinsic value with any group of dedicated, ambitious and competent medical men. The primary objective for our becoming and continuing to be doctors of medicine is the belief that with our knowledge, our skill and our willingness, we are able to improve the health conditions of our patients.

It is not given to every doctor of medicine to do research work and develop new programs or philosophies or search out new disease entities. We have such men in Michigan who are doing just that—even to the point of discovering new diseases or new treatment for them. Our fair share of that type of endeavor has been recorded during the year. That is enough about the purely scientific aspects of our professional work. We have recorded as much as we could in the limited space available.

There is a socio-economic part of the medical program and medical practice. This is invested in our various committees who are working for the benefit of our patients as well as ourselves, looking to the improvement of programs, processes and methods and availability of services. We have more than 700 committee members doing this work as an extra volunteer service outside of their working hours and caring for the sick and injured. The tremendous work of the Michigan State Medical Society and its members could not be accomplished without such volunteer service, which in many instances takes the man away from his work, not just for hours but days upon days.

There is another function of the medical profession, especially through its leaders, but basically and fundamentally by its every member, and that task is to make provision politically or otherwise, so that our less fortunate—but just as deserving—people of low income may receive just as attentive and just as valuable service as the fortunate who can and do pay for their services. Michigan and the whole nation went through such a period of stress during the great depression of the 1930's. Nearly 70 per cent of our present



active doctors know that period only by historic reading. For about ten years following the stock market crash of 1929, the income of our people was unbelievably low. A tremendous percentage could get only "made work" with stipulated minimum income. We had medical pioneers who recognized the fact that here was another duty we owed to our patients, to make provision by which they could get medical and hospital care. Ten years were devoted into developing what became the Blue Cross-Blue Shield programs. The methods were trial and error and taking chances, but seeing to it that destitute or nearly destitute people did get hospital and medical benefits.

During this same period, the Federal Government sent administrators to each county to supervise direct relief programs. The federal Congress began toying with a "national compulsory health insurance" program. The medical profession opposed the socialized medicine plan and developed a counter measure, our voluntary prepayment programs. Thus was staved off the federal compulsory program, but a federal social security program was started and has been expanded by almost every Congress.

The fundamental social security idea was for employed people to pay a percentage tax in conjunction with their employers, assessed against their gross income up to a limit. The scheme was said to build an "insurance fund" which would pay monthly benefits upon retirement. The amount to be received was small and became increasingly smaller as the purchasing value of the dollar began to depreciate.

Older people, upon retirement, have become an increasing problem. Almost all the Blue Shield programs and Blue Cross programs provided, in their group services, to cover people of all ages in the groups as long as they were working. About five years ago, a new concept was established, by which older or retired people could continue their insurance by direct pay or other means. Then followed the development of special contracts for senior citizen benefits. This matter also became a political and a labor item to see who could offer the most benefits. The medical profession assisted in the passage of the Kerr-Mills Bill through Congress to take care of those over age, those with inadequate income, and relief groups, and to provide for their care through regular taxation through state, county and federal government.

Bureaucrats and politicians—too many of them—conceived the idea of putting all of these retired people under social security and paying their hospital costs out of that so-called "reserve." The Kerr-Mills bill passed and, if permitted, is in successful operation throughout the country. The bureaucrats, the politicians, the irresponsible promisers favor the King-Anderson Bill which would place all retired people, no matter what their income, under social security benefits to receive health services, hospital services, rather than the customary monetary benefits, as the social security measure.

The whole program has been misrepresented, the people have been misinformed. They have been told this new addition to social security is insurance. It is not. It is a tax on those who are working. The group of 16 to 20 million over sixty-five would be included in this service program, but would not have paid one cent for it. That bill did not pass Congress, but the world has been put on notice that the bill will be pushed and probably passed in the coming session. If we wish to continue the private practice of medicine without dominating dictates from bureaucratism, our membership must be ready to fight again. This time it's "for keeps"!

The Blue Shield Program

The National Blue Shield held its annual program conference in Chicago, October 23-24. Problems of service, legislation, administration and eventualities were thoroughly discussed. Two whole days were devoted to an analysis and programming of what can and must be done. Speaking on the topic "This Choice Is Ours," Roger Fleming, director of the Washington office of the American Farm Bureau Federation, recalled Paul Revere and offered a new slogan "the federals are coming."

Another accomplishment from Michigan during this year has been the finalizing of the University of Michigan (McNerney) study of hospital and medical services. This is the culmination of five years of adverse medical publicity. The Governor's Commission, appointed by Governor Williams, set up a study to learn about hospital costs and medical costs and how they could be improved and reduced in amount. This committee worked three years; the Governor's commission by then had been disbanded and had to be reconstituted to receive the committee report. This report is about 1600 pages and has received a tremendous amount of national publicity, although it is not yet printed. It was presented to the Governor's commission, to the Governor, to a special legislative committee, to the Michigan State Medical Society, to the Michigan Hospital Association, to Michigan Medical Service, and to Michigan Hospital Service.

Special study committees of the Michigan State Medical Society, Blue Shield and Blue Cross are making detailed studies, outlining this report, condensing it and making its facts available. A special committee from the Legislature is also studying it.

During the past months, we have commented on some of the proposals and recommendations and reports. There are some items with which we cannot agree. The report recommends legislative change in our Blue Shield enabling act, with the elimination of all doctors of medicine from the Blue Shield Board and of all active hospital administrators from the Blue Cross Board. This would place us back thirty years when we were waiting for and begging insurance companies to develop a program of medical service. Insurance experts refused to do this because "medical services were uninsurable." It took the dedicated, hard-working, far-seeing doctors of medicine to recognize this depression activated need and to provide for a new industry. With the suggested lay board, we would have just another insurance company which would have learned that medical services can be insured but would have no sympathy with the medical profession and its inate problems in rendering the best service to the greatest number of people who need it.

Mr. McNerney also suggested that the medical men on the Board be self perpetuating. When Blue Shield was started in Michigan, the Council of the Michigan State Medical Society was the group which had done the years of research, the detail work and the organizational work. Naturally, they carried on in good proportion as the medical men on the original board. They could not be and have not been self-perpetuating because the corporate body of Blue Shield, which does the electing, is the seated House of Delegates plus the members of the board who are not members of the House of Delegates. Through the years, The Council members of the board have gradually diminished. Last year, there was only one member of the board who was also a Council member, and only five who had ever been Council members. The present Board for 1961-62 has no members of The Council and only three who have ever served on The Council. That disproves a self-perpetuating suggestion but brings up another item of concern. Michigan Medical Service, our Blue Shield, is a practically indispensable public fiduciary corporation, primarily for the benefit of our subscribers, assuring them services on a prepaid basis. It is a service guaranteed by the medical profession. Therefore, medical doctors, directors, are necessary to insure that subscribers get that service.

This corporation is expending for the benefit of its subscribers almost 100 million dollars a year. That is big business. We believe any corporation handling that amount of money, and responsible for the necessary business problems, would be very much concerned if its corporate body which has that responsibility, was prohibited from re-electing experienced directors for the Board of Trustees.

Our new president, Sidney Adler, in his acceptance speech, cautioned the board members that they were accepting great responsibilities to themselves, to their patients and to the public in assuming the responsibility of guidance of such an all-inclusive and all-important business. He promised to do his utmost to streamline the business agenda so it could be properly and efficiently handled. He would expect each and every member of the Board to take over and do without stint the tasks which may be and would be assigned.

Legislative Programs

In Michigan, we must be concerned as to what changes are made in the enabling act under which Blue Shield is operating. There is a strong influence being exerted through the McNerney report and from the Insurance Commissioner and others, to cut down the number of doctors on our Board and to take over our directing of Michigan's voluntary prepayment program. Such pressure also comes from Washington for the take-over by social security.

Charity Giving

A report just issued from the University of Michigan Research Center states that the American people give to charity, churches, and other welfare agencies some 17 billions of dollars a year or about 4 to 6 per cent of their income. The U. S. Census Bureau reports an income total in the United States for 1960 of $400,-200,000,000 and for 1961 was estimated at $414,650,-000,000. In the state of Michigan, the income for 1960 was $18,225,000,000 and in 1961 was estimated at $18,230,000,000. That amount, broken down into per capita income, represents, in 1960, $2,322 per individual person in Michigan, and for the whole United States, $2,223. The U. S. Census Bureau reports that the typical American family consists of father, mother and two children, living on an income of $5,600 in 1960. Thirty-one per cent of all American families are in the $7,000 to $15,000 income bracket. Only 8 per cent were in that bracket ten years ago.

This is the season of the year when we all clear up our affairs, balance our accounts and obligations and prepare for a new season. This includes many things we could do such as buying Christmas seals, making donations to our medical schools directly or through the American Medical Education Foundation.

We have passed through the United Fund solicitation period, Community Chest, Torch Drive, Red Feather or the solicitation of 20 to 200 independent organizations. Did each of us do his fair share? Sometimes these united solicitation groups contain one organization or one group which we personally do not approve and do not wish to support. Such questions occur in all solicitations. These objectors have generally been informed they could make their donation to the general fund specifying that no part of it go to that particular group which they disapprove, but they will have supported the many groups which they do approve.

Have you forgotten any? It is not too late.

Known as "The Health City"

This issue of THE JOURNAL MSMS, dedicated to the Calhoun County Medical Society, would not seem complete without a mention of the health-food industry in Battle Creek. Medicine, in its practice and extended benefits to patients, sparked an entirely new industry—packaged breakfast foods. It is likely that more United States residents know Battle Creek for its cereal industry than for any other product or activity.

The early beginnings of the Kellogg Company and the Post Division of General Foods go back almost 100 years. It was in the period of 1866 to 1891 that the companies formed to market health foods.

Today, there are four health food companies of national importance in Battle Creek—Kellogg's, Post, Ralston-Purina and National Biscuit Company. It is estimated these four firms employ 6,000 persons.

Calhoun County, with its 138,000 population, also is known for several other major industries. These would include the insurance industry and the firms that manufacture automotive parts, material-handling equipment and paper products.

The area is blessed with the education-cultural activities of the Kellogg Junior College and the Kingman Museum.

The Hospital Service Plan of Battle Creek is a unique organization tied in with the health program. Battle Creek has been active in United Fund giving, starting with the Welfare Funds of the early 1920's, Community Chest, and others. Ten years ago, the Board became convinced that some of the purely welfare funds supposed to pay indigent hospital costs could be better used. The Board created the Hospital Service Fund with instruction to confer with hospitals and doctors to find help for such needs. The worker has found hundreds of sources of help from unions, churches, relatives, fraternities, and numerous quasi-public agencies that could pay parts of these costs. The agency has no relief funds, but the first year produced over $15,000 for one hospital. The agency makes hundreds of investigations each month and has become indispensable.



Battle Creek has been serving, too, as national headquarters for the federal civic defense program.

National recognition also comes to the community because of the Kellogg Foundation, which has financed and encouraged research and undertakings in the areas of health, education and civic betterment.

Battle Creek and Calhoun County Medical Society played a very important part in the original research and plan development which led to the creation of Blue Shield.

Thank You

We give our thanks to A. Hamady, M.D., and his committee for cooperating in selecting original articles and securing some pictures for this issue. We also thank the *Battle Creek Evening News* for the use of some rare historic pictures, which were furnished by E. F. Jones, M.D., of the Veterans Hospital.

New Trial Ordered

An intermediate appellate court in California recently held that a damage suit against a physician, charging that his negligence during delivery had caused brain damage to an infant, should have been submitted to the jury. The court held that a nonsuit was improperly granted.

The mother testified that she had been taken into the delivery room although a nurse had reported that the cervix of the uterus had not been completely dilated. She said that the attending physician, and at his direction, two nurses and an anesthetist had pushed down on her stomach vigorously. A pediatrician testified that he had examined the child shortly after its birth and found it to be suffering cephalhematoma (a separation of the membrane covering the skull from the skull proper). He said that this was not a congenital anomaly, but was due to pressure upon the skull during delivery. An osteopath testified that the mother's pelvis was normal and that it was his opinion that the brain damage was caused by the pressure exerted on the mother's abdomen during delivery.

The attending physician testified that he had noticed no abnormalities of the mother that might contribute to an abnormal birth, that there was no evidence of injury to the mother during the pregnancy, that it was good practice to force a child out by pressure on the abdomen, and that if a crushing type of injury were great enough it could squeeze the brain and cause the condition from which the child was suffering.

The appellate court held that a nonsuit should not have been granted by the trial court. It said that nonsuit should be denied if there is any substantial evidence which, with the aid of all legitimate inferences favorable to the plaintiff, tends to establish the averments of the complaint. The case remanded to the trial court for a new trial.—Libby v. Conway, 13 Cal. Reptr. 830 (Cal., June 12, 1961)

* * *

Illinois Medical Witness Panel Fees

The previous report in *The Citation*, that the Illinois Medical Witness Panel Plan will be paid by the Illinois State Medical Society was in error. The experts' fees will be paid from funds which must come from a nonpartisan foundation which is national in scope and unimpeachable in character, in order to minimize any possible criticism.



LEGAL OPINION 1559

Editorial Comment

Why Doctors Leave Home

Grand Rapids Press, Oct. 15, 1961.

In his speech before the Kent County Medical Society last week, Charles R. Sligh, Jr., cited a report in the *London Economist* to the effect that "bright young English students with an aptitude for medicine were more and more deciding to enter the veterinary schools." They are becoming veterinarians to "escape the red tape and frustrations" of Britain's system of socialized medicine.

This is precisely the point that E. Lloyd Dawe, British surgeon and psychiatrist now practicing in this country, made recently in an article in the Nation's Business. "Practice under the National Health Service," he disclosed, "soon became intolerable for me, as it has for thousands of British and European doctors who have left their countries to practice in America."

The story Dr. Dawe has to tell must seem incredible to anyone ignorant of the way socialized medicine works. For example, only doctors on the staffs of hospitals may prescribe new drugs. Doctors who prescribe for their patients drugs not on the government-approved list are fined. Hospitals are woefully overcrowded—quite possibly because socialized medicine encourages everyone to seek hospital care—and patients have no choice to which hospital they will be assigned. British hospitals are jammed with elderly patients whose relatives find it easier to send them to hospitals than to look after them at home. Meanwhile, cases in dire need of hospital treatment can't gain admission—Dr. Dawe cites the case of several young patients with acute tonsilitis who were on the waiting list for a year.

The mass impersonal treatment of the sick obviously has some self-frustrating features. Much is made of the fact that the British do have a choice in selecting their family physician, but it's a poor choice because the average general practitioner has very little time for anyone. To earn as much as $4,000 a year, says Dr. Dawe, a physician in general practice, operating under the government's fixed-fee system, has to see 100 patients a day—which hardly gives him time enough to slip each patient a packet of aspirin and show him to the door. One of Dr. Dawe's colleagues made a decent living by raising chickens on the side. His chicken farm paid him more than his medical practice.

Yet the cost of Britain's National Health Service has increased fivefold. Obviously the doctors aren't getting the money. It's the clerks—there are two to three for each doctor in the system—who must keep the red tape tightly wound.

Small wonder, then, that medically-talented young Britons are "going to the dogs" to make a living. Sligh's comment, that if things stay on this course in Britain one will have to pretend to be a Pekingese to get the best treatment, probably wouldn't appear funny to the British. They have to live with socialized medicine. We don't. We can keep it out—though only if we continue to oppose such medical care legislation as that introduced in the last Congress. To be sure, there were strong denials of any attempt to regulate doctors. But the bill provided for the foot in the door. It stipulated that hospitals, nursing facilities and home care units would have to meet such requirements to participate as the secretary of health, education and welfare might provide. There comes that army of clerks with its forms, fines and flyspecking.

State Medical Journal Conference

The 1961 Conference of Editors of State Medical Journals was held in Chicago at the Sheraton-Chicago Hotel, October 30-31, 1961. Two full days and one evening involving talks and discussion, with analyses of all state medical journals. Theodore Wiprud, Managing Editor, *Medical Annals of District of Columbia,* presided. There were talks by Theodore R. Van Dellen, M.D., Medical Editor, *Illinois Medical Journal;* John H. Talbott, M.D., Editor, *Journal of the American Medical Association,* and Morris Fishbein, M.D., former Editor, *Journal of the American Medical Association.*



Doctor Haughey receives certificate for distinguished service.

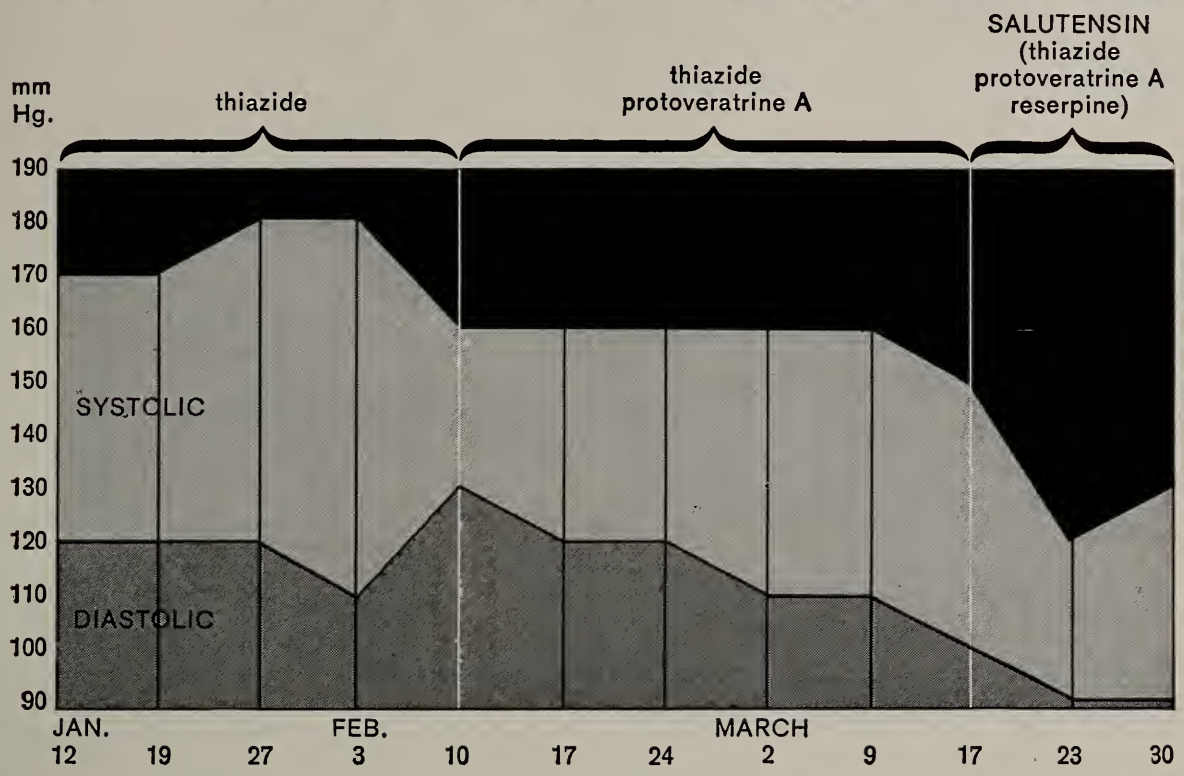
Panels and other discussions were presented by Theodore Wiprud, Managing Editor, *Medical Annals of the District of Columbia;* Wallace M. Yater, M.D., Editor, *Medical Annals of the District of Columbia;* Joseph Garland, M.D., Editor, *New England Journal of Medicine;* Edgar Woody, Jr., M.D., Editor, *Journal of the Medical Association of Georgia;* Harvey T. Sethman, Managing Editor, *Rocky Mountain Medical Journal;* James A. Waggener, Business Manager, *Journal of the Indiana State Medical Association,* and Jerome Enright, Business Manager, *Minnesota Medicine.*

O. M. Forkert again gave an evaluation of the format of the state medical journals. He made a critical analysis of each one of the thirty-four, studying them from seventeen lines of approach. Each editor received a critical analysis for his journal. Michigan was graded 83.

Monday evening, at the banquet, Wilfrid Haughey, M.D., Editor, The Journal of the Michigan State Medical Society, was given a certificate for distinguished service, presented by Walter E. Vest, M.D., Editor, *West Virginia Medical Journal.* Theodore Wiprud presided.

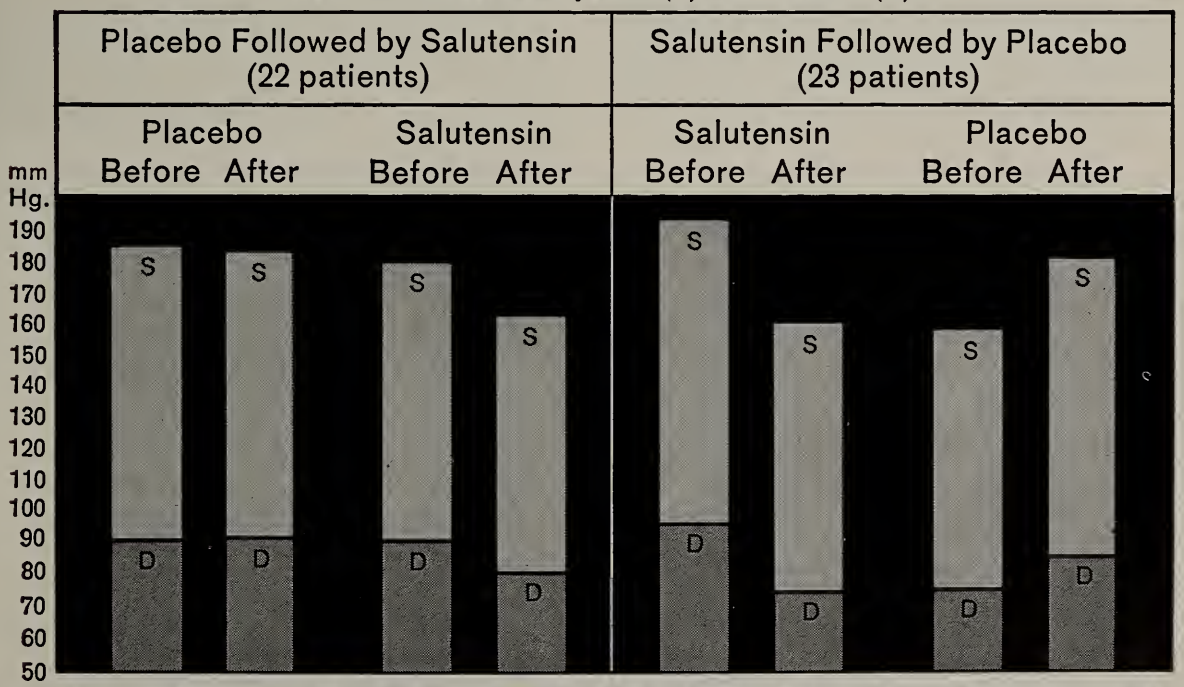
11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)



3½ WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS USING SALUTENSIN FROM THE START OF THERAPY IN A "DOUBLE BLIND" CROSSOVER STUDY

Mean Blood Pressures—Systolic (S) and Diastolic (D)



In this "double blind" crossover study of 45 patients, the mean systolic and diastolic blood pressures were essentially unchanged or rose during placebo administration, and decreased markedly during the 25 days of Salutensin therapy. (Smith, C. W.: Report to Department of Clinical Investigation, Bristol Laboratories.)

BRISTOL LABORATORIES / Div. of Bristol-Myers Co., Syracuse, N.Y.

MICHIGAN DEPARTMENT OF HEALTH

ALBERT E. HEUSTIS M.D., State Health Commissioner

Policy on Polio Vaccine

The Michigan Department of Health recommends that, for the present, the licensed oral poliomyelitis vaccine be used only in mass community programs in the event of an outbreak on a type specific basis and that all physicians and health officers continue to use and promote the use of Salk-type vaccine in the four-dose schedule, with a fifth dose five years after the fourth as the poliomyelitis immunizing agent of choice.

The Salk-type licensed vaccines are highly effective against all three types of poliomyelitis and are demonstrably safe. This is backed by tremendous protocol.

The oral vaccines now licensed are not complete. Type three is not yet licensed, and the Public Health Service indicates there are no immediate prospects of its being licensed. Oral vaccine requires multiple doses, as does the Salk-type vaccine. While it is judged safe and effective within the limits of present knowledge and by standards and tests now available, the accuracy of these tests is still open to controversy. The final proof may come only after extensive field use.

Tri-State Congenital Malformations Study

(Sponsored in Michigan by the Michigan Department of Health)

Medicine has made phenomenal progress in the treatment of congenital malformations. Functional correction of the club foot or the cleft palate is now taken for granted, and surgery of the congenital heart—undreamed of a quarter of a century ago—is a relatively common procedure in medical centers today. Although we have made gains in the surgical correction of some anomalies, in excess of 1 per cent of infants born in our hospitals are found to have observable malformations at birth. Most of these, fortunately, are minor; but some are so severe as to threaten life, or limit the individual's sense of well being and his usefulness to society.

We have made progress in our understanding of the mechanisms underlying these anomalies. Further progress will be largely dependent upon the efforts we are able to put into basic research. Radiation represents one of the recognized factors in these occurrences. Radiation can be man-made, or it can come from natural sources, such as the background radiation from rocks. Some correlation between the differing amounts of background radiation in communities and the occurrence of congenital defects has been observed; however, these observations are inconclusive.

The States of Michigan, Colorado and Minnesota are cooperating in a study which is being sponsored by the Division of Radiological Health of the Public Health Service. In this study, an attempt will be made to relate directly measured background radiation levels to the incidence of congenital malformations. This is a preliminary study to determine the feasibility and desirability of conducting a more definitive study. For this purpose, twenty-four urban areas in Michigan have been selected. Records of births and fetal deaths occurring to residents of each of the selected areas for the years 1958 and 1959 are being examined. Data from each of these records relating to the occurrence or non-occurrence of congenital malformations are placed on an individual worksheet for each birth.

In order to make the study as accurate as possible, it is important to obtain any additional information which may be on the hospital records of these births. Therefore, each of the designated birth records is to be examined in these hospitals to complete the individual worksheet for each birth. If death occurred during the first year of life, the related hospital records of that death are to be examined later for any further evidence of a malformation which may have been present. Any other conditions, treatment or data on hospital practices is not desired. The examination of the hospital records is being done in the hospitals concerned by senior medical students of the University of Michigan as part of their medical training. This, it is hoped, will be completed by April, 1962.

The completed worksheets go to the University of Minnesota where the data will be entered on IBM cards. Composite data on the occurrence of defects will be made available to the participating hospitals when compiled.

(Continued on Page 1568)

Cooperation Urged In Common Struggle

The "Right of Free Choice" was stressed by Francis C. Brown, president of the Schering Corporation at the recent 63rd annual convention of the National Association of Retail Druggists in Miami Beach. In part, Mr. Brown said:

"We must not permit ourselves the comforting illusion of striving to save freedom abroad while we allow it to be destroyed by default at home.

"Unfortunately, through complacency, indifference, and ignorance, the erosion of liberty within our borders has increased its tempo in recent years.

"The three fundamental elements of medicine in this country—the physician, the pharmacist, and the pharmaceutical manufacturer—have worked together in a climate invigorated by the spirit of freedom, and together they have provided medical care unsurpassed anywhere in the world. In these troubled days, we must be ever alert to preserve our freedom at home, to live according to our fundamental beliefs, and to accept the dangers and the responsibilities of economic and political democracy."

More than 75,000 Work in Michigan Hospitals

The hospital industry in Michigan is among the ten largest employers in the state. It is estimated that in 1960, about 76,000 persons worked full-time or part-time in the 246 Michigan hospitals which reported employment statistics. Together, these hospitals employed over 3 per cent of the state's total wage and salary workers.

More than 1,600,000 full-time and part-time personnel were employed in approximately 6,900 hospitals in the United States in 1960. This figure represents 2.6 per cent of total employment in nonagricultural establishments last year. Hospitals employ more workers than do such industries as basic steel, automobiles, electrical machinery or interstate railroads.

National Leader

Miss Adelia M. Beeuwkes, Ann Arbor, is the new president of the American Dietetic Association. Miss Beeuwkes, widely recognized as an educator in the field of nutrition, received a bachelor of science degree at Michigan State University, her master's degree at the University of Michigan, and completed her dietetic internship at the University of Michigan Medical Center.



ANCILLARY 1567

Southeastern Michigan Cancer Division Re-Elects Dr. Nelson

The Southeastern Michigan Division of the American Cancer Society has re-elected Harry M. Nelson, M.D., Detroit, president, and John R. McDonald, M.D., Detroit, vice president.

Newly elected as chairman of the board was Arthur J. Vorwald, M.D., Detroit.

Among those elected to membership on the Board of Directors was Alan Thal, M.D., Detroit.

Doctor Adler, New President of Michigan Blue Shield

Sidney Adler, M.D., Detroit, is president of Michigan Blue Shield, elected at the October Board meeting. He succeeds G. Thomas McKean, M.D., Detroit, who served as president for two terms but declined renomination because of the press of his medical practice.



Others newly elected were James Blodgett, M.D., Detroit, and James M. Gillen, General Motors Corporation, as vice presidents. Also elected for the first time as secretary was Allan K. Cameron, M.D., Saginaw.

Waldo I. Stoddard, Michigan National Bank, Grand Rapids, was re-elected treasurer for his sixth term.

The Board of Directors re-elected Sumner G. Whittier executive director and also named him assistant treasurer. Neal McCue, administrative assistant, was named assistant secretary.

Doctor Adler, in his acceptance speech, emphasized his appreciation that much and exacting work must be done to reverse the trend and make Michigan Medical Service a continuing and growing organization offering to its subscribers every benefit they may expect including the constant effort among the doctors to have happy and contented subscribers and to increase the popularity of Michigan Medical Service in Michigan. He promised to devote every effort to further streamlining and preparing materials for the board meetings. He said he will expect all doctors on the board to serve on the Medical Advisory Committee.

At the annual organization meeting, the first order of business was the introduction of new members of the board—F. E. Alfenito, M.D., Grand Rapids, was unable to be present; E. C. Baumgarten, M.D., Grosse Pointe Woods, who was a member previously; Robert M. Bookmyer, M.D., Birmingham; Hugh Caumartin, M.D., Saginaw; Alfred H. Whittaker, M.D., Detroit (all of whom represent the Michigan State Medical Society); Ralph C. Hutchins, Alma, representing Michigan Hospital Association, and Rt. Rev. Robert L. DeWitt of Detroit, representing the public.

In the financial report as of August 31, it was brought out that Michigan Medical Service has paid out for services to its beneficiaries, $511,963,231. (The first and only Blue Shield to go over the half billion mark.) Michigan Medical Service is now paying out for benefits in excess of $7.5 million a month.

UM High in Number of MD Graduates

A relatively small number of colleges and universities prepare the great majority of entering medical students.

The Association of American Medical Colleges has published a list of the top 25 schools for each two-year period—1952, 1954, 1957, 1958 and 1960. Harvard ranks first in each group: 169, 174, 162, 182, and 164. Michigan ranks second in every year but 1956, when it was third. The students were 55, 136, 145, 164, and 145. In 1956, Illinois was second with 151. Wayne State University gets into the listing for 1958 and 1960 with 74 and 69 students.

TRI-STATE CONGENITAL MALFORMATIONS STUDY

(Continued from Page 1564)

Information obtained from individual records is completely confidential and for research purposes only. This is assured by Act 39 of the Public Acts of 1957 of the State of Michigan. The project has been approved by the State Council of Health.

With the completion of the vital records and hospital parts of the study, exact measurements will be made of the background radiation levels in each of the selected areas. This will be correlated with the data on malformations from those areas for significant differences and relationships.

The study concerns only births during 1958-59 within the city limits of the following cities: Adrian, Albion, Alpena, Benton Harbor, Big Rapids, Charlotte, Grand Haven, Holland, Iron Mountain, Ishpeming, Jackson, Kingsford, Lapeer, Marquette, Mason, Midland, Mt. Pleasant, Petoskey, Romeo, Sault Ste. Marie, South Haven, Tecumseh, Three Rivers, and Traverse City.

Brief and to the Point

NATIONAL LEADER—Albert D. Ruedemann, M.D., Detroit is the new president-elect of the American Academy of Ophthalmology and Otolaryngology. He will assume the presidency in January 1963. Members elected Dr. Ruedemann recently at their 66th annual session in Chicago. In order to accept the presidency, Dr. Ruedemann resigned the post he has held for 28 years as secretary for instruction in ophthalmology of the Academy of Ophthalmology.

* * *

APPOINTED—Dr. Henry F. Vaughan, Ann Arbor, is a member of the new citizens advisory committee to the U. S. Food and Drug Administration. He was appointed by HEW Secretary Ribicoff. The committee will make recommendations regarding the steps which the Department and the Food and Drug Administration should take to insure adequate protection to citizens in their use of foods, drugs, therapeutic devices, cosmetics and laws enforced by the FDA.

* * *

REPORT DIABETES EFFORT—More than 200 Michigan physicians participated in the 1960 Diabetes Detection Drive, reporting 3,532 persons tested, 101 positive tests and 29 new diabetics found as a result. In addition, 52 new and 32 potential diabetics were found as a result of Dreypak test kit screening and 168 new diabetics were discovered through Clinitron blood sugar screening programs. Altogether 40,101 persons were tested and 249 new diabetics found.

* * *

POPULAR EVENT—The Medical Career Day held recently at the University of Michigan had the largest turnout of any previous career conference. One hundred seventy-five students from various Michigan and from a few out of state colleges attended. Michigan schools represented were Albion College, Aquinas College, Calvin College, Flint Junior College, Hillsdale College, Hope College, Michigan State University, University of Detroit, the University of Michigan, and Wayne State University. Dean William N. Hubbard and many faculty members participated on the program.

* * *

HOLD WORKSHOP—Hospital administrators, doctors, nurses and safety experts attended the recent University of Michigan workshop on problems of patient safety in hospitals. Sessions were conducted by George H. Lowrey, M.D., Frank W. Reynolds, M.D., Paul E. Hodgson, M.D., and Carey McCord, M.D., all of Ann Arbor.

* * *

OFFER ENCOURAGEMENT—More than 100 resident physicians and interns in teaching hospitals received financial assistance from the George W. Merck Memorial Loan Fund in its second year of operation. Nineteen medical schools participated in the Fund, established "to encourage deserving interns and residents to seek the best possible



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post-graduate training by providing loan funds that will supplement the stipends available to them at teaching hospitals." Seventy per cent of the loans went to residents.

* * *

ON GERONTOLOGICAL BOARD—V. K. Volk, M.D., Saginaw, is a member of the board of directors for the Michigan Gerontological Society. Frederick Swartz, M.D., Lansing, past-president, also serves on the board for the coming year.

* * *

WAYNE SYMPOSIUM—A two-day Symposium on Rheumatology and Metabolism was held recently at the Wayne County Medical Society building, the event sponsored by Wayne State University's College of Medicine.

* * *

FELLOWSHIPS EXTENDED—Contribution to international medicine and American medical education has prompted Smith, Kline & French Laboratories to extend its foreign fellowship program, administered by the AAMC, for one extra year. Originally set up on a three-year basis, the program is going into what would have been its final year of offering fellowships to junior and senior medical students for medical work and study in underdeveloped areas of the world.

* * *

STUDENT HELP—The Association of American Medical College has published a 197-page book listing sources of financial assistance available from universities and other agencies for graduate study in the medical sciences. The publication lists over 1,000 fellowships, scholarships, traineeships and awards covering more than 100 specialties.

* * *

ON TOUR—C. Paul Hodgkinson, M.D., Lathrup Village, immediate past president of the American College of Obstetrics and Gynecology, is on a month-long tour of South America where he will deliver several scientific papers in Spanish.

* * *

KELLOGG FELLOWSHIPS—This academic year, 49 members of the health professions of Latin America will be in the United States for advanced study through fellowships awarded by the W. K. Kellogg Foundation of Battle Creek. Twenty-seven are physicians. Under this program, there are now six students at the University of Michigan and two at Wayne State—two taking medical nursing, one gastroenterology, two oral hygiene or diagnosis, two hospital administration and one clinic administration.

* * *

MUSEUM OF HEALTH—An American Museum of Health has been granted a charter as an educational institution by the University of the State of New York. A national advisory group of distinguished leaders in medicine, public health and related fields is being formed to assist in the development of the museum. The newly created institution will erect a $3,500,000 Hall of Medicine and Public Health at the World's Fair 1964-1965 in New York City.

* * *

OPENS OFFICE—The Medical Library Association has opened headquarters in Chicago and appointed Helen Brown Schmidt as executive secretary. The new office is at 919 N. Michigan Avenue, Chicago.

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

February 27, 28, March 1 and 2, 1962

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Teaching Demonstrations
Instructional Courses

Scientific Exhibits worthy of real study and helpful and time-saving Technical Exhibits.

The Chicago Medical Society Annual Clinical Conference should be a MUST on the calendar of every physician. Plan now to attend and make your reservations at the Palmer House.

EXAMS SCHEDULED—The American Board of Obstetrics and Gynecology announces that the next scheduled examination (Part II), oral and clinical, for all candidates, will be conducted at the Edgewater Beach Hotel, Chicago, April 9-14, 1962. Full details may be obtained from Robert L. Faulkner, M.D., board secretary, 2105 Adelbert Road, Cleveland.

* * *

WAYNE GRANT—Wayne State University recently received a grant of $238,495 from the U. S. Public Health Service National Institute of Health to support research in the Wayne Neurological Center for Cerebrovascular Research, under the direction of John Stirling Meyer, M.D., Detroit.

* * *

NEW LOCATION—For the first time, the University of Michigan held its annual "Cancer Retreat" this year at the Michigan State University conference center at Gull Lake, near Hickory Corners. Forty doctors and scientists participated.

* * *

TRAIAN LEUCUTIA, M.D., Detroit, was installed as president of the American Roentgen Ray Society at the annual meeting in Miami Beach. He succeeds Harold G. Reineke, M.D., of Cincinnati.

About 1,500 radiologists and guests registered to hear some 50 papers and attend 68 refresher courses.

PROFESSIONAL HONORS—G. B. Pierce, Jr., M.D., associate professor of pathology at The University of Michigan Medical Center, has been extended one of the top professional honors of the American Urological Association. Dr. Pierce has accepted an invitation to give the Guiteras Lecture a memorial to the founder of the Association and termed "the outstanding scientific presentation" of the Association's 57th annual meeting in Philadelphia next May. The invitation to Dr. Pierce comes in recognition of his extensive research on the transplantation and growth of testicular tumors.

Reed Nesbit, M.D., professor of surgery and head of the University of Michigan urology section, was similarly honored by the Association two years ago.

Three University of Michigan graduates were honored in November for outstanding achievement in their chosen professions. They are: John B. Grant, M.D., of the School of Tropical Medicine, University of Puerto Rico, consultant to the Rockefeller Foundation; Dennis Flanagan of New York City, editor of *Scientific American* magazine; and Thor Johnson, orchestral director at Northwestern University and formerly conductor of the Cincinnati Symphony. All received Outstanding Achievement Awards consisting of a citation at a special convocation held as part of a joint concert of the Duke University and the University of Michigan Men's Glee Clubs.

Laboratory Examinations
Tissue Diagnosis

Allergy Tests
Autopsies
Bacteriology
Basal Metabolism
Chemistry
Electrocardiograms
Hematology
Papanicolaou Stain
Pregnancy Tests
Protein Bound Iodine
Urinalysis
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MEETINGS U.S.A.

1962

January

American Academy of Orthopaedic Surgeons, Palmer House, Chicago, Jan. 27-Feb. 1. Mr. John K. Hart, 29 East Madison St., Room 910, Chicago 2, Executive Secretary.

February

American Academy of Allergy, Denver-Hilton Hotel, Denver, Feb. 5-7. Mr. James O. Kelley, 756 North Milwaukee St., Milwaukee 2, Executive Secretary.

American Academy of Forensic Sciences, Drake Hotel, Chicago, Feb. 22-24. Dr. W. J. R. Camp, 1853 W. Polk St., Chicago 12, Secretary-Treasurer.

American Academy of Occupational Medicine, Pittsburgh, Pa., Feb. 7-9. Mr. William C. Stronach, 20 N. Wacker Dr., Chicago 6, Executive Director.

Central Surgical Association, Cincinnati, Feb. 22-24. Dr. Carl E. Lischer, 457 N. Kingshighway, St. Louis 8, Secretary.

Congress on Medical Education and Licensure, Palmer House, Chicago, Feb. 3-6. Dr. Walter S. Wiggins, 535 N. Dearborn St., Chicago 10, Director, AMA Council on Medical Education and Hospitals.

Society of University Surgeons, Cleveland, Feb. 8-10. Dr. C. Frederick Kittle, University of Kansas Medical Center, Kansas City 12.

Michigan Clinical Institute, Sheraton-Cadillac Hotel, Detroit, February 28, March 1-2.

March

American College of Surgeons, Sectional Meeting, Sheraton-Cadillac Hotel, Detroit, March 5-7. Dr. William E. Adams, 40 E. Erie St., Chicago 11, Secretary.

American Pharmaceutical Association, Convention Center, Las Vegas, March 26-29.

April

Aerospace Medical Association, Atlantic City, April 9-12. Dr. William J. Kennard, Washington National Airport, Washington 1, D. C., Executive Vice-President.

American Academy of General Practice, Las Vegas, Nev., April 6-13. Mr. Mac F. Cahal, Volker Blvd., at Brookside, Kansas City 12, Mo., Executive Director.

American Academy of Neurology, Statler-Hilton Hotel, New York City, April 23-28. Mr. Thomas D. Swedien, 4307 E. 50th St., Minneapolis 17, Executive Secretary.

American Academy of Pediatrics, spring meeting, Statler-Hilton, New York City, April 30-May 2. Dr. E. H. Christopherson, 1801 Hinman Ave., Evanston, Ill., Executive Director.

American Association of Railway Surgeons, Chicago, April 12-14.

American Association for Thoracic Surgery, Chase-Park Plaza Hotel, St. Louis, April 16-18. Dr. Henry T. Bahnson, Johns Hopkins Hospital, Baltimore 5, Secretary.

American College of Allergists, Hotel Radisson, Minneapolis, April 1-6. Dr. Maurice C. Barnes, 1310 Austin Ave., Waco, Texas.

American College of Obstetricians and Gynecologists, Palmer House, Chicago, April 2-5. Mr. Donald F. Richardson, 79 W. Monroe St., Chicago 3, Executive Secretary.

American College of Physicians, Bellevue-Stratford Hotel, Philadelphia 4, Executive Director.

American Proctologic Society, Deauville Hotel, Miami Beach, April 30-May 3. Dr. Norman D. Nigro, 7815 E. Jefferson Ave., Detroit 14, Secretary.

American Society of Internal Medicine, Benjamin Franklin Hotel, Philadelphia, April 6-8. Mr. G. Tod Bates, 350 Post St., San Francisco 8, Executive Director.

Industrial Medical Association, Pick-Congress Hotel, Chicago, April 10-12. Dr. Emmett B. Lamb, 23 East Ohio St., Indianapolis 4, Secretary.

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IN MEMORIAM

JACQUES P. GRAY, M.D., sixty-one, Detroit, director of special medical services for Parke, Davis & Company, died October 13, 1961.

Doctor Gray was director of the Hillsdale County Health Department, 1940-42; dean of the school of medicine and professor of public health medicine at the Medical College of Virginia, 1942-46, and at the University of Oklahoma School of Medicine in 1946-47, joining Parke-Davis later in 1947.

Doctor Gray was a 1928 graduate of Johns Hopkins University School of Medicine; in 1935, he received a doctor's degree in public health from Harvard University School of Public Health.

Memberships included the American Public Health Association and the American Association for the Advancement of Science. Active in the American Medical Writers Association, Doctor Gray coordinated the February, 1961 number of THE JOURNAL MSMS, which was dedicated to medical writing.

AUSTIN Z. HOWARD, M.D., sixty, Detroit, Receiving Hospital's night superintendent since 1931 died October 1, 1961.

A graduate of Detroit College of Medicine, Doctor Howard joined the staff of Receiving Hospital as an intern in 1926 and later became the youngest man ever to hold the post of chief surgeon at the hospital. Total blindness, as a result of glaucoma, forced his retirement in April, 1961. He was on the staff of Detroit Memorial and Wayne County General Hospitals. He was an honorary member of the Detroit Police Officers Association and the Lieutenants and Sergeants Association.

HENRY C. MORITZ, M.D., seventy-one, Detroit obstetrician, died October 25, 1961.

Doctor Moritz taught at Wayne State University College of Medicine. He was a charter member of the Michigan Gynecologic and Obstetric Society.

THOMAS C. SMITH, M.D., sixty-eight, Kalamazoo psychiatrist, died October 19, 1961.

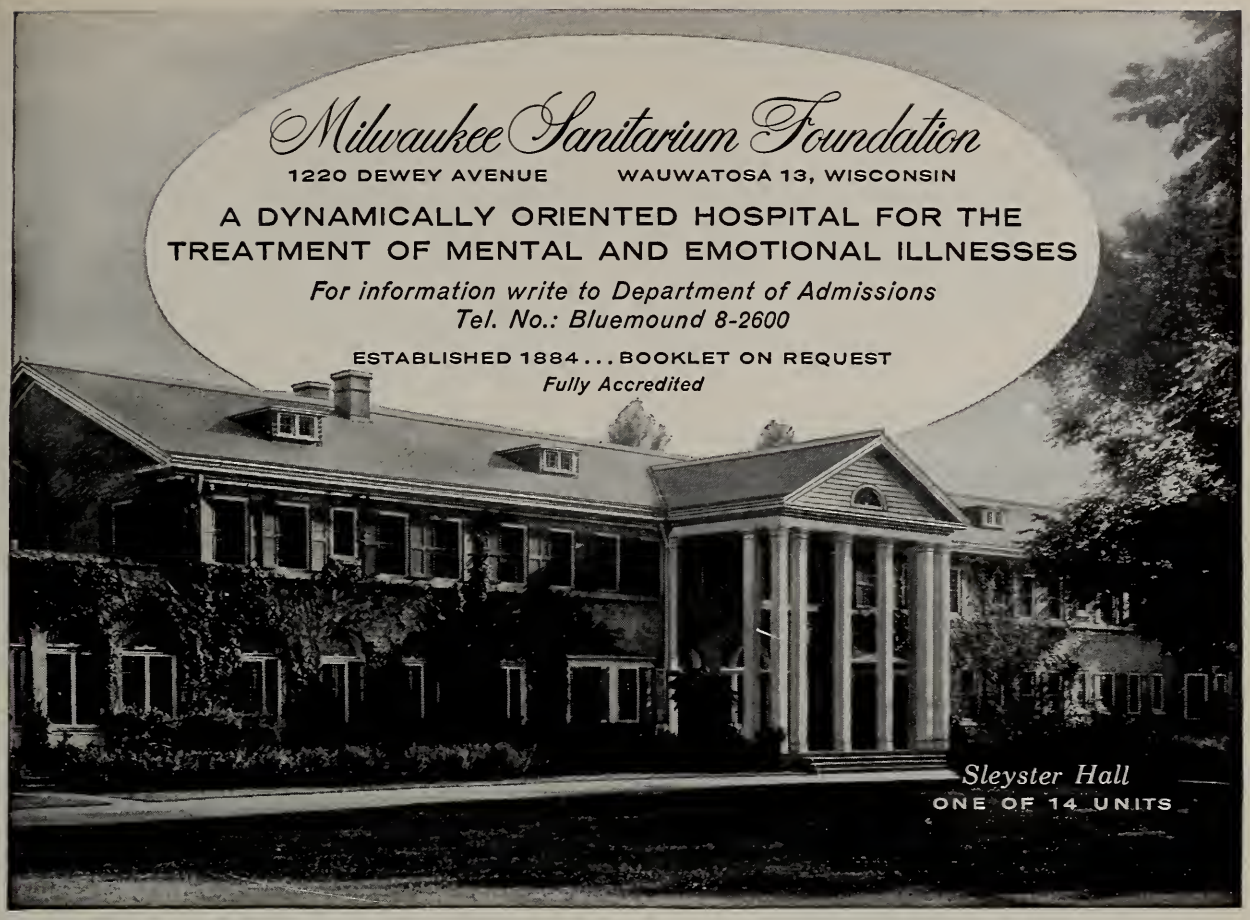
A native of Chicago, Doctor Smith was on the staff of Kalamazoo State Hospital since 1949.

JAMES E. WATSON, SR., M.D., sixty-four, Detroit surgeon for 37 years, died September 27, 1961.

A graduate of Detroit College of Medicine and Surgery in 1921, Doctor Watson did postgraduate work at Mayo Clinic. Doctor Watson had been on the staff of Children's Hospital 25 years. A fellow of the American College of Surgeons, he was also on the staffs of Mt. Carmel Mercy and Wayne County General Hospitals.

GEORGE E. WINTER, M.D., ninety-one, Jackson physician for more than fifty years, died September 20, 1961.

Say you saw it in the Journal of the Michigan State Medical Society



Doctor Winter had retired in 1954 and moved to Florida, where he was living at the time of his death. He was a graduate of the Detroit College of Medicine in 1895 and began practice in Jackson in 1901, specializing in ophthalmology and otolaryngology. He was a Life Member of the Michigan State Medical Society.

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COMMUNICATIONS

The Editor will be glad to receive and consider for publication letters containing information of general interest to physicians throughout the State or presenting constructive criticisms on controversial issues of the day.

To Representatives of
Ingham County Medical Society and
Michigan State Medical Society:

We think the 1961 Michigan State University Career Carnival was the best, ever. We are prejudiced, of course, but we have come through thirteen career carnivals and it seemed that the displays were better this year, the recruiters more effective, and the students more enthusiastic.

Your own display was one of the attractions that brought the students in, not just the seniors, but also the underclassmen who wanted to know more about you and the field you represented.

From the Committee and myself, thanks to representatives of the Ingham County Medical Society and the Michigan Medical Society for contributing to the success of the Career Carnival.

Sincerely,
EDWIN B. FITZPATRICK
Placement Bureau
Michigan State University

•

To The Council
Michigan State Medical Society:

Into the life of every man comes one event that mounts higher in stature, in satisfactions, in pleasure, and in memory than all other activities and actions of his years.

In my life, this great circumstance was my happy experience as President of the Michigan State Medical Society.

I cannot attain even the threshold of expression to recount the many joys that this assignment brought me. But one of the greatest dividends was association with members of The Council. Added to this is my indelible debt of gratitude to the members of this working body for their good advice which helped to keep my administrative feet on the right road.

My thanks, gentlemen, for your kindness and your friendship. The many trying tasks of the Presidency were made far less arduous and oft-times most pleasurable because of your constant guidance. Knowing that The Council was behind the President gave me the courage to carry on to the best of my ability, sometimes against discouraging odds.

I shall always be filled with humble gratitude to The Council for invaluable assistance afforded me during the past Society year.

Sincerely,
KENNETH H. JOHNSON, M.D.
Immediate Past President
Michigan State Medical Society

•

To Every Michigan State Medical Society Member:

The present Michigan State Medical Society will be 100 years old June 5, 1965. Its history up to the year 1930 is told in the two-volume work entitled "Medical History of Michigan" which was compiled and edited by a committee with C. B. Burr, M.D., as Chairman, and published under the auspices of the Michigan State Medical Society.

This history was a tremendous job which could not be duplicated today. It is a valuable reference work and we feel that a short summary of the material in it relating to the earlier days of the Society should be part of our 100th Anniversary story.

We are asking you this question. Have you any material relating to the Michigan State Medical Society since the year 1930, such as newspaper or magazine clippings, letters, diaries, documents, pictures, or do you know of anyone who might possess this kind of material?

It may seem that 1965 is a long way off, but it takes time to go over the material, put it into shape, have it edited, and printed.

Will you help, if possible?

WILLIAM J. STAPLETON, JR., M.D.
Historian, Michigan State Medical Society

(See also Page 1582)

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The Doctor's Library

Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

BLOOD COAGULATION: COLLECTED PAPERS. By Walter H. Seegers and Associates, 1957-1960: W. J. Baker, G. Ballerini, R. K. Brown, G. Casillas, M. H. Cho, C. Fell, K. Fukutake, P. Halick, Y. Hatta, E. R. Hecht, J. F. Johnson, S. A. Johnson, R. H. Landaburu, J. M. Lee, W. G. Levine, E. F. Mammen, K. D. Miller, W. H. Seegers, R. S. Shepard, S. Shulman, D. F. Steichele, W. R. Thomas, M. Yoshinari.

Walter H. Seegers, of Detroit, and his associates present a paper bound volume, in which he has collected forty abstracts or publications on blood coagulations and his collected papers. He also has a listing of more than 130 publications. We are very happy to receive it and congratulate him most sincerely on an extremely well executed job. The book is complimentary.

PHARMACOGNOSY. By Edward P. Claus, Ph.D., Dean and Professor of Pharmacognosy, Ferris Institute School of Pharmacy; formerly Professor of Pharmacognosy and Head of Department, University of Pittsburgh School of Pharmacy; Member of Advisory Panel on Pharmacognosy, National Formulary. Fourth edition, thoroughly revised. 227 illustrations; 1 plate in color. Philadelphia: Lea & Febiger, 1961. Price, $12.50.

Pharmacognosy, we assume, is a manufactured term to designate everything one can about pharmaceutical preparations and other things used in the treatment of disease, knowing the intimate details and action and recognizing the similar conditions present. The author, who is associated with Ferris Institute, Big Rapids, Michigan, has presented a most challenging understanding of pharmacology in its minutest ramifications.

GOOD-BYE, DOCTOR ROCH. By Andre Soubiran. Translated by Helen Sebba. Garden City, New York: Doubleday & Company, Inc., 1961. Price, $4.50.

Written by a French physician, this novel concerns the struggles of a newly appointed medical director of a psychiatric hospital in his efforts to bring reforms to the institution. The methods of the administration and the attendants reminded the physician of the time he had spent in a concentration camp. The usual ingredients of a novel such as love and jealousy are woven in. This is interesting reading for leisure time.

H.E.A.

REHABILITATION OF A CHILD'S EYES. By Herbert M. Katzin, M.D., F.A.C.S., Director and Board Member, Eye Bank Laboratory, and Attending Surgeon, Manhattan Eye, Ear and Throat Hospital, New York, N. Y., and Geraldine



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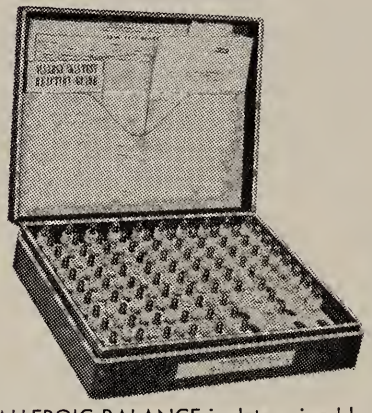
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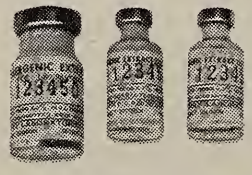
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Wilson, R.N., Orthoptic Technician, New York, N. Y. Third edition of Scobee's "Rehabilitation of A Child's Eyes." Illustrated. St. Louis: C. V. Mosby Company, 1961. Price, $3.75.

Crossed eyes are the most important condition considered in this book, which gives a complete description and the mechanism and what to do. Emphasis is placed on necessity to get these children at two or three years of age—or before four—in order to correct the refractive errors and save the sight in both eyes. The book is really written for the use of parents. This is an excellent presentation of the subject.

PRACTICAL PEDIATRIC DERMATOLOGY. By Morris Leider, M.D., Associate Professor of Dermatology and Syphilology, New York University Post-Graduate Medical School, New York, N. Y.; Visiting Physician in Charge, Service of Dermatology, Bellevue Hospital, New York, N. Y.; Associate Attending Physician, University Hospital and New York University-Bellevue Medical Center, New York, N. Y.; Diplomate of the American Board of Dermatology and Syphilology. With 280 photographs and 15 drawings. Second edition. St. Louis: C. V. Mosby Company, 1961. Price, $13.75.

This is an excellent book for pediatricians and general practitioners, and dermatologists will find it good for reference. The information is up to date, practical, and easy to read. The high quality of the paper, type and binding is a credit to the publishers. Many will find the formulary of 101 dermatologic preparations for topical application very useful.

H.E.A.

TRAITOR WITHIN. Our Suicide Problem. By Edward Robb Ellis and George N. Allen. Garden City, New York: Doubleday & Company, Inc., 1961. Price, $3.95.

This book is a fascinating study on the suicide problem. Recent statistics reveal that 300 people attempt it each day, and fifty are successful. It seems to hit particularly at the more intelligent and highly educated segment of the world's population. The study goes into such factors as sex, race, season, economics, occupations, geography, suicide epidemics, sanity and many other related items. Methods of suicide and suicide notes are dealt with. The book is highly interesting for leisure time reading.

H.E.A.

NURSING HOME ADMINISTRATION. Training materials for administrators of nursing, boarding, and mental hygiene homes for the aged. By John D. Gerletti, Ed.D., Educational Coordinator, Attending Staff Association, Professor of Public Administration, University of Southern California, with C. C. Crawford, Ph.D., Educational Consultant, Attending Staff Association, Emeritus Professor of Education, University of Southern California, and Donovan J. Perkins, M.S., Business Manager, Attending Staff Association. 472 pages. Downey, California: (7601 East Imperial Highway) Attending Staff Association, 1961. Price, $6.50.

The authors are not physicians, but they are dealing with a problem in which all doctors are extremely interested, the problem of a nursing home—when, and where, and how. How to get it, the site to be selected, the planning, admin-

istrating, and building. The book is not set in linotype, but typewritten with typewriting face. The presentation of the book is odd and intriguing, and the subject matter is extremely valuable. The book is published, not by a publishing house but by the attending staff association in Downey, California. All the authors are actively interested in education and administration.

The book will prove of value to those in any area where there is a problem of nursing homes, homes for the aged, boarding homes, and mental hygiene problems.

WILLIAMS OBSTETRICS. Revised by Nicholas J. Eastman, Professor Emeritus of Obstetrics, Johns Hopkins University; Obstetrician-in-Chief Emeritus to the Johns Hopkins Hospital, and Louis M. Hellman, Professor and Chairman, Department of Obstetrics and Gynecology, State University of New York, Downstate Medical Center; Director of Obstetrics and Gynecology, Kings County Hospital, Brooklyn. New York: Appleton-Century-Crofts, Inc., 1961. Price, $16.00.

This twelveth edition of Williams standard text of obstetrics has brought the subject matter up to date and deleted outmoded and useless material. Much of the subject matter has been derived from the author's work at Johns Hopkins Hospital and includes a new chapter on fetal malformations and fetal physiology. The subjects of hyperbilirubinemia, placental transfer and fetal hemostasis are excellently treated. The chapters on abortion are complete, from the standpoint of both prevention and treatment.

The material on endocrines and the toxemias is very thorough. For more detailed information, there is a complete bibliography. The last chapter, which deals with operative obstetrics, includes excellent diagrams and pictures.

This is a very comprehensive text for the student and serves as a reference for the busy practitioner.

J.R.P.

RELIEF OF SYMPTOMS. By Walter Modell, M.D., F.A.C.P., Director of Clinical Pharmacology and Associate Professor of Pharmacology, Cornell University Medical College, New York, N. Y.; Attending Physician, New York Veterans Administration Hospital, New York, N. Y.; Associate Visiting Physician, Bellevue Hospital, New York, N. Y.; Member, General Committee on Revision, United States Pharmacopeia XVII; Editor, *Clinical Pharmacology and Therapeutics*. 352 pages. Second edition. St. Louis: C. V. Mosby Company, 1961. Price, $11.50.

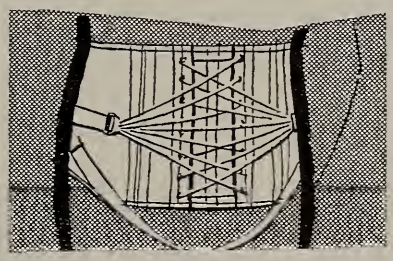
This is the second edition of a well-written textbook, devoted to a discussion of measures commonly employed in the relief of symptoms. The author, who has been a member of the Editorial Board of Cornell Conferences on Therapy, has written this book from a series of formal lectures and informal seminars, with students, interns, and house officers, in his association with Cornell University Medical College in New York.

The book is divided into three principal parts, (1) Theory (2) Practice and (3) Counsel. It is interesting and very easy reading, and does offer a different approach than that of the standard textbook of medicine. A wide variety of subjects is included, from various types of pain, anorexia, constipation, diarrhea, gas, to convulsions, muscle spasms and dysmenorrhea. The third part on Counsel consists of a dis-

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cussion of Cortisone and its relation to the masking of symptoms. A series of twenty-four helpful tables of listings of the various categories of drugs are interspersed throughout the text, under both generic and proprietary names. The initial theoretical section has been condensed, and most of the text is devoted to Part II, Practice.

The book succeeds in presenting a readable case for symptomatic medicine which is its avowed intention. For this purpose alone, it can be recommended, but it does not in any sense take the place of a standard, well-written textbook of medicine.

R.W.B.

HYPNOSIS IN OBSTETRICS. Obstetric Hypnoanesthesia. By Ralph V. August, B.S., M.D., F.A.C.O.G., F.I.C.S., Consultant to Departments of Obstetrics and Gynecology, Mercy Hospital, Muskegon, Michigan; Chief of Department of Obstetrics, Hackley Hospital, Muskegon, Michigan. Technique of hypnosis recorded by Dr. August. New York-Toronto-London: Blackiston Division, McGraw-Hill Book Company, Inc., 1961. Price, $10.00.

This volume is unique in that the author derives his material from his own practice. This book contains numerous case histories and follows them through the entire pregnancy. Doctor August not only induces his own hypnoanesthesia, but delivers the baby or does his surgical procedure as well.

The chapter on pain as well as the one on contraindications is very well treated. To illustrate the material further, the publishers have enclosed a 33⅓ r.p.m. long-playing record of Doctor August's actual recordings of his patients being delivered under hypnoanesthesia.

This text is interesting reading and brings the physician up to date on one of the newer aspects of obstetrics.

J.R.P.

CLINICAL DIAGNOSIS BY LABORATORY EXAMINATIONS. John A. Kolmer, M.S.; M.D.; Dr. P.H.; Sc.D.; LL.D.; F.A.C.P.; F.A.C.D., (Hon.). Professor Emeritus of Medicine and Director of the Institute of Preventive Medicine and Public Health, Temple University School of Medicine; Professor of Medicine, Temple University School of Dentistry. Third edition. New York: Appleton-Century-Crofts, Inc., 1961. Price, $10.00.

This is the third edition of a textbook of slightly more than 500 pages devoted to the clinical significance of changes in laboratory examinations in relation to diagnosis and differential diagnosis of disease. It is said to be completely rewritten. The references at the end of each of the twenty-two chapters indicates that most of the literature on which the text is based comes from the period 1950 through 1957. Only occasional later references are noted.

Careful review left the reviewer with the impression that the book is particularly strong on serology, immunology, mycology, and bacteriology. It seemed particularly weak in chemistry, discussions related to metabolic disease, and endocrinology. For example, the discussion of the Vanden-Bergh test fails to point out that the direct reacting bilirubin is the conjugated form, and that the indirect reacting bilirubin represents that which has not yet been conjugated by the liver. Similarly, discussion of protein-bound iodine and radio-active iodine, not to mention some others, seems rather sketchy and inadequate.

The book is well bound and well illustrated. It contains 142 helpful tables inserted in appropriate areas of the text, which are an aid in formulating differential diagnosis.

A book which survives three editions certainly has a good deal to recommend it, which this one does. It is a classic reference in clinical pathology by a distinguished author.

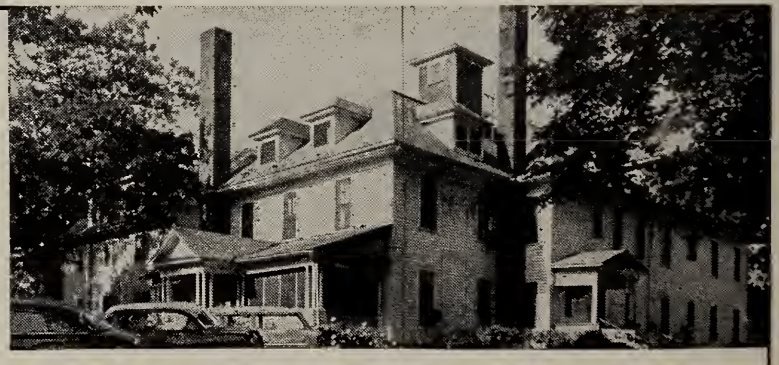
R.W.B.

ESSENTIAL HYPERTENSION. An International Symposium. Chairman: F. C. Reubi, Berne. Edited by K. D. Bock, Basle, and P. T. Cottier, Berne. 81 figures. Berline-Goettingen-Heidelberg: Springer-Verlag, 1961.

This is an International Symposium on Hypertension sponsored by the Ciba Foundation, which was held in Berne, in June, 1960. It represents a varied collection of papers on the subject by international authorities. It begins with a paper by Page on "The Mosaic Theory" of hypertension, stressing the fact that arterial blood pressure is compounded of a large variety of facets. Recent advances in some of these facets are discussed. The question of inheritance of high blood pressure is thoroughly gone over. The rôle of salt intake in the development of essential hypertension is discussed. Renal hemodynamics, renal pressor mechanisms and adrenocortical function is presented in relation to their role in essential hypertension. Transcripts of the general discussions are included throughout the text.

Pharmacology of the new hypotensive drugs is presented, and combined drug therapy is discussed by able workers. A

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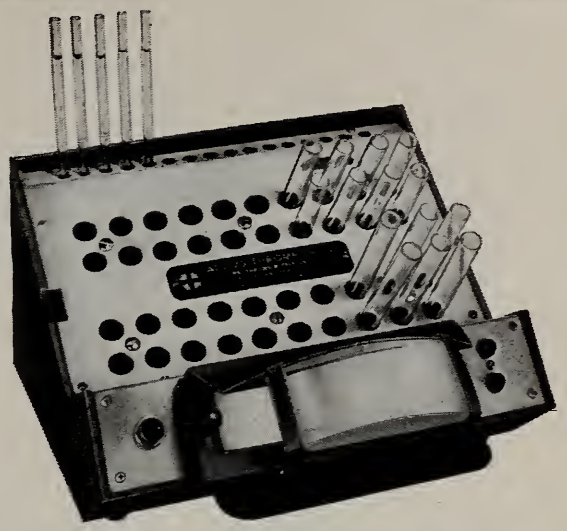


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section on results of surgical therapy is included. It will be noted that the papers in this symposium show considerable variation in their scope.

Some of these essays will be of considerable interest to the thoughtful practitioner, and particularly to the physician who desires to review some of the basic physiology, pharmacology, and therapeutics of essential hypertension.

The book is small, well illustrated with tables and graphs, and carefully referenced. A summary of each paper is included at the end. Certainly, most of the current thinking on the subject is included here.

R.W.B.

THE CARDIAC ARRHYTHMIAS. A Guide for the General Practitioner. By Brendan Phibbs, M.D., Casper Clinic, Casper, Wyoming. St. Louis: C. V. Mosby Company, 1961. Price, $7.50.

This is a very worth-while book, of slightly more than 100 pages, well printed and illustrated, and written from a practical point of view. As noted in the preface, the book is written to teach physicians who are not cardiologists to diagnose and treat cardiac arrhythmia. The basic tool employed is the electrocardiogram and the text attempts to outline, as simply as possible, both recognition and rationale of development of each of the principal arrhythmias.

Initially, a review of the basic anatomy and physiology is presented with discussion and illustrations of both normal and abnormal cardiac mechanism. Each arrhythmia is separately discussed and illustrated by numerous electrocardiograms and practice exercises are included for EKG identification at the end of the book.

A plan of treatment for each arrhythmia which is concise and specific as to dosages and exact procedures, is carefully outlined.

The book is very useful as a guide to the general practitioner in the handling of these problems. It fulfills its avowed purpose admirably without oversimplification.

R.W.B.

W. B. Saunders Company features the following recent books in their full-page advertisement appearing elsewhere in this issue:

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BOOKS RECEIVED

IMPORTANCE OF THE VITREOUS BODY IN RETINA SURGERY. With Special Emphasis on Reoperations. Second Conference of the Retina Foundation, May 30 and 31, 1958. Edited by Charles L. Schepens, M.D., Boston, Mass. 130 figures, including 4 in color; 3 plates in full color. St. Louis: C. V. Mosby Company, 1960. Price, $15.00.

CULTURE METHODS FOR INVERTEBRATE ANIMALS. A compendium prepared cooperatively by American zoologists under the direction of a committee from Section F of the American Association for the Advancement of Science: Paul S. Galtsoff, Frank E. Lutz, Paul S. Welch, and James G. Needham, Chairman; assisted by many specialists whose names appear in connection with their respective contributions to this volume. New York, N. Y.: Dover Publications, Inc., 1959. Price, $2.75.

BLOOD DISEASES OF INFANCY AND CHILDHOOD. By Carl H. Smith, M.A., M.D., Professor of Clinical Pediatrics, Cornell University Medical College, New York, N. Y.; Attending Pediatrician, The New York Hospital, New York, N. Y.; Consulting Pediatrician, Beekman-Downtown Hospital, New York, N. Y.; Fitkin Memorial Hospital, Neptune, N. J.; Misericordia Hospital, New York, N. Y.; New York Infirmary, New York, N. Y.; St. Joseph's Hospital, Far Rockaway, N. Y.; Sea View Hospital, Staten Island, N. Y.; Consulting Hematologist in Pediatrics, Lenox Hill Hospital, New York, N. Y. Illustrated. St. Louis: C. V. Mosby Company, 1960. Price, $15.00.

HAEMOPOIESIS. Cell Production and Its Regulation. Ciba Foundation Symposium. Editors for Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Maeve O'Connor, B.A. 107 illustrations. Boston: Little, Brown and Company, 1961. Price, $11.00.

MATHEMATICAL BIOPHYSICS. Physico-Mathematical Foundations of Biology. By N. Rashevsky, Professor and Chairman, Committee on Mathematical Biology, The University of Chicago. Third revised edition. Volume 2. New York: Dover Publications, Inc., 1961. Price, $2.50.

MEDICAL CARE OF THE ADOLESCENT. By J. Roswell Gallagher, M.D., Chief of the Adolescent Unit, The Children's Hospital Medical Center, Boston, and Lecturer on Pediatrics, Harvard Medical School, and Staff Physician of the Adolescent Unit, New York: Appleton-Century-Crofts, Inc., 1960. Price, $10.00.

MEDICINE FOR NURSES. By M. Toohey, M.D., M.R.C.P., D.C.H., Physician, New End Hospital, London. With a Chapter on Psychological Medicine by Henry R. Rollin, M.D., D.P.M., Psychiatrist, Horton Hospital, Epsom, and New End Hospital, London. Fourth Edition. Edinburgh and London: E. and S. Livingstone Ltd., 1959. Price, $5.00.

COMMUNICATIONS

(Continued from Page 1576)

Otto K. Engelke, M.D., President
Michigan State Medical Society

Dear Doctor Engelke:

It has come to our attention that a number of physicians may be administering Type I and Type II oral polio vaccines both on an individual and a group basis.

It is the recommendation of the Michigan Department of Health that these two presently licensed oral vaccines NOT be used routinely, but only in the event of an outbreak of a specific type.

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While the licensed oral vaccines are judged safe and effective within the limits of present knowledge, final proof can come only after the extensive field tests. The safety and efficacy of Salk vaccine is, of course, backed by tremendous protocol. We strongly urge that all physicians continue to use and promote the use of Salk vaccine in the four-dose schedule with a fifth dose five years after the fourth as the poliomyelitis vaccine of choice.

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STACKS

The Journal

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Michigan State Medical Society
Ninety-Fifth Annual Session
September 25-27, 1960

Digest of Proceedings of the House of Delegates

Michigan State Medical Society

Ninety-Fifth Annual Session

September 25-27, 1960

Digest of Proceedings

A summary of the 1960 MSMS Annual Session
appeared in The Journal MSMS for November 1960,
pages 1616-1620

MSMS Ninety-Fifth Annual Session---1960
House of Delegates Proceedings

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VII.	Report of Delegates to American Medical Association	25	66	approved
VIII.	Report of Woman's Auxiliary to MSMS	27	66	approved
IX.	Report of Michigan State Medical Assistants Society	28	66	approved
X.	Michigan Medical Service Report	29	90	approved
XI.	Selection of Michigan's Foremost Family Physician	37	80	
XII.	Resolutions:			
	1. Medical Care Study Committee	37	81	amended and approved
	2. Election Campaigns	38	73	amended and approved
	3. Descriptive Coding of Medical Services	38	90	referred to Relative Value Study Committee
	4. Blue Shield Policy	38	91	received for information only—no action taken
	5. Loan Fund for New Physicians	39	78	amended and approved
	6. Hospital Emergency Care	39	91	referred to The Council
	7. Repeal Basic Science Law	39	73	sub. res. adopted

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		Introduction of Business	*Reference Committee Report*	*Action*
8.	Wages of Nurses	39	73	approved
9.	Nurses Training Program	40	73	amended and approved
10.	Postgraduate Medical Education Committee Membership (Bylaws, Chap. 11, Sec. 2)	40	70	amended and approved
11.	MSMS Councilors—Members of House of Delegates (Bylaws, Chap. 9, Sections 1 & 2 and Chap. 10, Sec. 2)	40	70	disapproved
12.	MSMS Councilors—Elections (Bylaws, Chap. 9, Sec. 10-g)	40	70	disapproved
13.	MSMS Councilors—Term of Office (Bylaws, Chap. 12, Sec. 1)	41	70 & 86	amended and approved
14.	Petition for revocation of charter: Clarification of MSMS Bylaws (Chap. 1, Sec. 2)	41	71 & 86	corrected and approved
15.	Rename MSMS Section on Medicine	41	78	approved
16.	Uniform Transfer of Membership	41	78	approved
17.	Appointment of MSMS Historian	41	81	approved
18.	Consistency of County-MSMS Bylaws (Bylaws, Chap. 1, Sec. 1)	41	71 & 86	amended and approved
19.	MSMS Councilors Holding Two Positions	42	81	amended and approved
20.	Election of MSMS Secretary (held over from 1959)	42	71	disapproved
21.	Election of MSMS Treasurer (held over from 1959)	42	71	disapproved
22.	Committee on Postgraduate Medical Education (held over from 1959)	42	70	disapproved
23.	Voting Power of MSMS Secretary and Treasurer (held over from 1959) (Constitution, Art. X, new Sec. 3)	43	71	amended and approved
24.	Employee Recognition	43	79	approved
25.	The Instituting of a Presidents Program	43	75	amended and approved
26.	Presidents Program: Public Health, Full Time Local Units	44	75	amended and adopted
27.	Presidents Program: Basic Research	44	75	amended and adopted
28.	Presidents Program: Maternal and Child Health	44	75	amended and adopted
29.	Presidents Program: Prevention of Disease	44	75	approved
30.	Presidents Program: Early Detection of Disease	45	76	amended and approved
31.	Presidents Program: Disease Control	45	76	amended and approved
32.	Presidents Program: Mental Health	46	76	amended and approved
33.	Presidents Program: Fulfillment of Patient Potential	46	77	amended and approved
34.	Presidents Program: Help for the Aged	46	77	amended and approved
35.	Presidents Program: Emergency Medical Care	47	77	amended and approved
36.	Presidents Program: Meeting Need for Medical Students and Increased Medical School Facilities	47	77	corrected and approved
37.	Presidents Program: Education	48	78	approved
38.	Presidents Program: Financing Health Care	48	78	approved
39.	Visual Screening Program	48	78	amended and approved
40.	Insurance Report Forms	48	80	amended and approved
41.	MMS Payment for Surgical Assistants	49	91	amended and approved
42.	General Practice Residencies	50	81	disapproved
43.	Study Committee re Indigent Physicians	51	81	amended and approved
44.	Councilor Districts (Proposed Amendment to Constitution, Art. X, Sec. 1 & 12)	42	70	laid over for one year
45.	Separation and Divestment of the Michigan State Medical Society from Michigan Medical Service	49	91	disapproved

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		Introduction of Business	*Reference Committee Report*	*Action*
46.	Payment for Major Medical Services by Michigan Medical Service	49	90	Referred to Relative Value Study Committee.
47.	Policy for Prepaid Medical Care Insurance Plans	50	92	amended and adopted
48.	Family Income—Michigan Medical Service	50	92	no action taken
49.	Loading Charges Made on Unit Values—Michigan Medical Service	50	99	no action taken
50.	Civil Defense	51	78	amended and approved
51.	Task Force	51	82	disapproved and referred to Public Relations Committee
52.	Michigan Crippled Children Commission Fee Schedule	63	87	approved
53.	Residency Training Programs	62	82	amended and approved
54.	Revised Rules and Order of Business of House of Delegates	62	86	amended and approved
55.	The People-to-People Health Foundation	63	87	approved
56.	House of Delegates Resolutions (Proposed amendment to Bylaws, Chap. 9, Sec. 10)	80	86	laid over for one year
57.	Technical and Economic Advice	80	82	disapproved
XIII.	Presentation made by Chairman of National Blue Shield Plans	52	89	(See Item XIV-3 and action thereon)
XIV.	*Reports of Committees of the House of Delegates:*			
1.	Permanent Advisory on Fees	14		no report from Reference Committee
2.	Committee on Committees	51	84	amended; some items referred to Comm. on Const. & Bylaws; balance of report was approved
3.	Committee to Meet with National Blue Shield Commission	52	89	amended and approved
4.	Special Committee to Review MSMS Constitution and Bylaws	53	71 & 86	amended and approved with some recommendations laid over for one year
5.	Committee to Study Problem of Malpractice	54		no report from Reference Committee
6.	Committee to Study MSMS Publications	55	66	amended and approved
7.	Special Committee to Study Election of Councilors on Geographic Basis and the Status of Councilors as Voting Members of the House of Delegates	55	70	see actions on Resolutions 11-12-13-44
8.	Committee to Review Financial Structure of MSMS	55	68 &84	amended and approved
XV.	*Reports of MSMS Standing Committees:*			
1.	Committee on Postgraduate Medical Education	62	67	approved
2.	Preventive Medicine Committee and Sub-Committees	62	67	approved and recommendations made
3.	Public Relations Committee and Sub-Committees	62	67	approved
4.	Ethics Committee	62	68	approved
5.	Legal Affairs Committee	62	68	approved

		Introduction of Business	*Reference Committee Report*	*Action*
XVI.	*Reports of MSMS Special Committees:*	62 & 84		
	1. Scientific Radio Committee	62	68	approved
	2. Advisory Committee to Woman's Auxiliary	62	68	approved
	3. Advisory Committee to Michigan State Medical Assistants Society	62	68	approved
	4. Study Committee on Prevention of Highway Accidents	62	68	approved and recommendations made

XVII.	*Reports of Reference Committees:*		
	1. On Reports of The Council: (a) Annual Reports of The Council (64)	64 & 83	
	2. On Officers Reports: (a) Speaker's Remarks (66); (b) President's Remarks (66); (c) President-Elect's Remarks (66); (d) Delegates to the American Medical Association (66); (e) President of Woman's Auxiliary (66); (f) President of Michigan State Medical Assistants Society (66)	66	
	3. On Reports of Standing Committees: (a) House of Delegates Committee to Study MSMS Publications (66); (b) Postgraduate Medical Education Committee (67); (c) Preventive Medicine Committee (67); (d) Rheumatic Fever Control Committee (67); (e) Maternal Health Committee (67); (f) Venereal Disease Control Committee (67); (g) Tuberculosis Control Committee (67); (h) Iodized Salt Committee (67); (i) Occupational Medicine Committee (67); (j) Mental Health Committee (67); (k) Child Welfare Committee (67); (l) Geriatrics Committee (67); (m) Committee on Diabetes Control (67); (n) Public Relations Committee (67); (o) Ethics Committee (68); (p) Legal Affairs Committee (68).	66	
	4. On Reports of Special Committees: (a) Scientific Radio Committee (68); (b) Advisory Committee to Woman's Auxiliary (68); (c) Advisory Committee to Michigan State Medical Assistants Society (68); (d) Committee on Study of Prevention of Highway Accidents (68); (e) House of Delegates Committee to Review Financial Structure of MSMS (68)	68 & 84	
	5. On Constitution and Bylaws: (a) Resolutions 10 and 22 re Postgraduate Medical Education (70); (b) Report of Special Committee to Study the Election of Councilors on Geographic Basis and the Status of Councilors as Voting Members of the House of Delegates and Resolutions Nos. 11, 12, 13, 44 (70); (c) Resolution No. 14 (71); (d) Resolution No. 18 (71); (e) Resolution Nos. 20, 21, 23 (71); (f) Annual and Supplemental Reports of Special Committee to Review Constitution and Bylaws (71)	70 & 86	
	6. On Special Memberships:	72	
	7. On Legislation and Public Relations: (a) Resolution No. 2 (73); (b) Resolution No. 8 (73); (c) Resolution No. 9 (73); (d) Resolution No. 7 (73);	73 & 87	

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	(e) Presidents Program Resolutions: No. 25 (75), No. 26 (75), No. 27 (75), No. 28 (75), No. 29 (75), No. 30 (76), No. 31 (76), No. 32 (76), No. 33 (77), No. 34 (77), No. 35 (77), No. 36 (77), No. 37 (78), No. 38 (78)			
8.	On Hygiene and Public Health:..... (a) Resolution No. 39 (78)		78	
9.	On National Defense and Disaster Planning:..... (a) Resolution No. 50 (78)		78	
10.	On Miscellaneous Business:..... (a) Resolution No. 5 (78); (b) Resolution No. 15 (78); (c) Resolution No. 16 (78); (d) Resolution No. 24 (79); (e) Resolution No. 40 (80)		78	
11.	On Resolutions:..... (a) Resolution No. 1 (81); (b) Resolution No. 17 (81); (c) Resolution No. 19 (81); (d) Resolution No. 42 (81); (e) Resolution No. 43 (81); (f) Resolution No. 51 (82); (g) Resolution No. 53 (82); (h) Resolution No. 57 (82); (i) Committee to Study Problem of Malpractice —no report from Reference Committee.		81	
12.	On Rules and Order of Business:..... (a)Resolution No. 54 (86)		86	
13.	On Medical Service and Prepayment Insurance:..... (a) Medical Care Insurance Committee Report (87); (b) Joint Committee of MSMS and National Blue Shield Association (89); (c) Michigan Medical Service Annual Report (90); (d) Relative Value Scale Subcommittee (90); (e) Resolution No. 3 (90); (f) Resolution No. 46 (90); (g) Resolution No. 4 (91); (h) Resolution No. 6 (91); (i) Resolution No. 41 (91); (j) Resolution No. 45 (91); (k) Resolution No. 47 (92); (l) Resolution No. 48 (92); (m) Resolution No. 49 (92); (n) Recommendations of Reference Committee on Medical Service and Prepayment Insurance (93); (o) Permanent Advisory Committee on Fees—no report by Reference Committee.		87	
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3.	On Constitution and Bylaws:..... (a) Resolution No. 56 (86); (b) Resolution No. 13 (86); (c) Resolution No. 14 (86); (d) Resolution No. 18 (86)		86	
4.	On Legislation and Public Relations:..... (a) Resolution No. 52 (87); (b) Resolution No. 55 (87)		87	
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	3. Presentation of Scroll and Key to Immediate Past President Milton A. Darling, M.D.	83		
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Michigan State Medical Society

DIGEST OF PROCEEDINGS OF THE 1960 HOUSE OF DELEGATES

SUNDAY EVENING SESSION
September 25, 1960

The Ninety-fifth Annual Meeting of the House of Delegates of the Michigan State Medical Society, held on September 25-27, 1960, at the Sheraton-Cadillac Hotel, Detroit, Michigan, convened at 8:00 p.m. J. J. Lightbody, M.D., Speaker of the House of Delegates, presiding.

I. RECORD OF ATTENDANCE

	1st	2nd	3rd	4th	5th
J. J. Lightbody, M.D., Speaker	x	x	x	x	x
H. F. Falls, M.D., Vice Speaker	x	x	x	x	x
D. Bruce Wiley, M.D., Secretary	x	x	x	x	x
G. B. Saltonstall, M.D., Member-at-large	x	x	–	x	x
A. V. Wenger, M.D., Honorary Member	–	–	–	–	–

DELEGATES

ALLEGAN					
Lewis F. Brown, M.D.	x	x	x	x	x
ALPENA-ALCONA-PRESQUE ISLE					
John W. Bunting, M.D.	x	x	x	x	x
BARRY					
Alexander B. Gwinn, M.D.	x	x	x	–	x
BAY-ARENAC-IOSCO					
David A. Bowman, M.D.	x	x	x	–	x
Stanley A. Cosens, M.D.	x	x	–	–	x
BERRIEN					
Noel J. Hershey, M.D.	x	x	x	x	x
Paul O. Rague, M.D.	x	x	x	x	x
BRANCH					
Robert M. Leitch, M.D.	x	x	x	x	x
CALHOUN					
Harvey C. Hansen, M.D.	x	x	x	x	x
Geo. T. Kelleher, M.D.	x	x	x	x	x
CASS					
Sherman L. Loupee, M.D.	x	x	x	x	x
CHIPPEWA-MACKINAC					
Donald D. Finlayson, M.D.	x	x	x	x	x
CLINTON					
Franklin W. Smith, M.D.	x	x	x	x	x
DELTA-SCHOOLCRAFT					
James R. Dehlin, M.D.	x	x	x	x	x
DICKINSON-IRON					
Donald R. Smith, M.D.	–	x	x	x	–
EATON					
Byron P. Brown, M.D.	x	x	x	x	x
GENESEE					
Lawrence G. Bateman, M.D.	x	x	x	x	x
William F. Buchanan, M.D.	x	x	x	x	x
Clifford W. Colwell, M.D.	x	x	x	x	x
J. Leonidas Leach, M.D.	x	x	x	x	x
Frank D. Johnson, M.D.	x	x	x	x	x
John E. Wentworth, M.D.	x	x	x	x	–
GOGEBIC	not represented				
GRAND TRAVERSE-LEELANAU-BENZIE					
Frank H. Power, M.D.	x	x	x	x	x
GRATIOT-ISABELLA-CLARE					
John M. Wood, M.D.	x	x	x	x	x
HILLSDALE					
Arthur W. Strom, M.D.	x	x	x	x	x
HOUGHTON-BARAGA-KEWEENAW					
Andrew M. Roche, M.D.	x	x	–	–	x
HURON					
Charles W. Oakes, Jr., M.D.	x	x	x	x	x
INGHAM					
Lawrence A. Drolett, M.D.	x	x	x	x	x
Herbert W. Harris, M.D.	x	x	x	x	x
Robert M. Stow, M.D.	x	x	x	x	x
Franklin L. Troost, M.D.	x	x	x	x	x
John M. Wellman, M.D.	x	x	x	x	x
IONIA-MONTCALM					
Robert E. Rice, M.D.	x	x	x	x	x
JACKSON					
John W. Rice, M.D.	x	x	x	x	x
Ross V. Taylor, M.D.	x	x	x	x	x
KALAMAZOO					
W. Kaye Locklin, M.D.	x	x	x	x	x
Don Marshall, M.D.	x	x	x	x	x
Donald G. May, M.D.	x	x	x	x	x
Frederick C. Ryan, M.D.	x	x	x	x	x
KENT					
Felix S. Alfenito, Jr., M.D.	x	x	x	x	x
W. Clarence Beets, M.D.	x	x	x	x	x
Frederick C. Brace, M.D.	x	x	x	x	x
J. Russell Brink, M.D.	x	x	x	x	x
James A. Ferguson, M.D.	x	x	x	x	x
Wm. J. Fuller, M.D.	x	x	x	x	x
J. Duane Miller, M.D.	x	x	x	x	x
A. R. Vanden Berg, M.D.	x	x	x	x	x
LAPEER					
Harry B. Zemmer, M.D.	x	x	x	x	x
LENAWEE					
George C. Wilson, M.D.	x	x	–	–	–
and R. E. Dustin, M.D.	–	–	–	x	x
LIVINGSTON					
Harold C. Hill, M.D.	x	x	x	x	x
LUCE	not represented				
MACOMB					
Daniel L. Rousseau, M.D.	x	x	x	x	x
Edward G. Siegfried, M.D.	x	x	x	x	x
MANISTEE	not represented				
MARQUETTE-ALGER					
E. R. Elzinga, M.D.	x	x	x	x	x
MASON					
Herbert G. Bacon, Jr., M.D.	x	x	x	x	x
MECOSTA-OSCEOLA-LAKE					
Paul Ivkovich, M.D.	x	x	x	x	x
MENOMINEE					
John R. Heidenreich, M.D.	x	x	x	x	x
MIDLAND					
Harold L. Gordon, M.D.	x	x	x	x	x
MONROE					
Samuel N. Kelso, Jr., M.D.	x	x	x	x	x
MUSKEGON					
DeVere R. Boyd, M.D.	x	x	x	–	x
H. Clay Tellman, M.D.	x	x	x	x	x
NEWAYGO					
J. Paul Klein, M.D.	x	x	x	x	x
NORTH CENTRAL					
Louis F. Hayes, M.D.	x	x	x	x	x
NORTHERN MICHIGAN					
Gerald A. Drake, M.D.	x	x	x	x	x
OAKLAND					
Robert M. Bookmyer, M.D.	x	x	x	x	x
Chauncey G. Burke, M.D.	x	x	x	–	x
Harold A. Furlong, M.D.	x	x	x	x	x
Merle A. Haanes, M.D.	x	x	x	x	x
Michael C. Kozonis, M.D.	x	x	x	x	x
Paul T. Lahti, M.D.	x	x	x	x	x
Arthur R. Young, M.D.	x	x	x	x	x
Walter J. Zimmerman, M.D.	x	x	x	x	x
OCEANA					
Willis A. Hasty, M.D.	x	x	x	x	x

ONTONAGON					
Wm. F. Strong, M.D.	x	x	–	–	–
OTTAWA					
John H. Kitchel, M.D.	x	x	x	x	x
SAGINAW					
Vernon V. Bass, M.D.	x	x	x	x	x
Joseph P. Markey, M.D.	x	x	x	–	x
A. Carl Stander, M.D.	x	x	x	x	x
ST. CLAIR					
John J. Coury, M.D.	x	x	x	x	x
ST. JOSEPH					
Russell A. Springer, M.D.	x	x	x	x	x
SANILAC					
Keate T. McGunegle, M.D.	x	x	x	x	x
SHIAWASSEE					
Claude L. Weston, M.D.	x	x	x	x	x
TUSCOLA					
Edward N. Elmendorf, II, M.D.	x	x	x	x	x
VAN BUREN					
Thomas J. Dillon, M.D.	x	x	x	x	x
WASHTENAW					
Otto K. Engelke, M.D.	x	x	x	x	x
Theodore G. Kabza, M.D.	x	x	x	x	x
Henry A. Scovill, M.D.	x	x	x	x	x
R. Wallace Teed, M.D.	x	x	x	x	x
Victor M. Zerbi, M.D.	x	x	x	–	x
WAYNE					
Sidney Adler, M.D.	x	x	x	x	x
Ralphael Altman, M.D.	x	x	x	x	x
Louis J. Bailey, M.D.	x	x	x	x	x
Gaylord E. Bates, M.D.	x	x	x	x	x
James B. Blodgett, M.D.	x	x	x	x	x
George T. Bradley, M.D.	x	x	x	x	x
John R. Brown, M.D.	x	x	x	x	x
Duncan A. Cameron, M.D.	x	x	x	–	x
Clarence L. Candler, M.D.	x	x	x	x	x
Meyer O. Cantor, M.D.	x	x	x	x	x
Wm. S. Carpenter, M.D.	x	–	x	x	x
Wyman C. C. Cole, Sr., M.D.	x	x	x	x	x
Ralph R. Cooper, M.D.	x	x	x	x	x
Herbert W. Devine, M.D.	x	x	x	x	x
Edwin H. Fenton, M.D.	x	x	–	x	x
George S. Fisher, M.D.	x	x	x	x	x
James D. Fryfogle, M.D.	x	x	x	x	x
Perry C. Gittins, M.D.	x	x	x	x	x
Hugh W. Henderson, M.D.	x	x	x	x	x
Joseph Hickey, M.D.	x	x	x	x	x
Homer A. Howes, M.D.	x	x	x	x	x
Ralph A. Johnson, M.D.	x	x	x	x	x
Alfred M. Large, M.D.	x	x	x	x	x
Luther R. Leader, M.D.	x	x	–	x	x
Floyd B. Levagood, M.D.	x	x	–	x	x
Arthur B. Levant, M.D.	x	x	x	x	x
Max L. Lichter, M.D.	x	x	x	x	x
Edgar E. Martmer, M.D.	x	x	x	x	x
Don W. McLean, M.D.	x	x	x	x	x
Joseph G. Molner, M.D.	x	x	–	–	–
George J. Moriarty, M.D.	x	x	x	x	x
Robert L. Novy, M.D.	x	x	x	x	x
Eugene A. Osius, M.D.	x	x	x	x	x
Clarence I. Owen, M.D.	x	x	x	x	x
Alvin E. Price, M.D.	x	x	x	x	x
A. Hazen Price, M.D.	x	x	x	x	x
Francis P. Rhoades, M.D.	x	x	x	x	x
A. Zack Rogers, M.D.	x	x	x	–	x
Jack Rom, M.D.	x	x	x	x	x
Albert D. Ruedemann, Sr., M.D.	x	x	x	x	x
Charles W. Sellers, M.D.	x	x	x	x	x
John G. Slevin, M.D.	x	x	x	x	x
David I. Sugar, M.D.	x	x	x	x	x
Robert G. Swanson, M.D.	x	x	x	x	x
Donald N. Sweeny, Jr., M.D.	x	x	x	x	x
Edward J. Tallant, M.D.	x	x	x	x	x
Milton R. Weed, M.D.	x	x	x	x	x
Jacob F. Wenzel, M.D.	x	x	x	x	x
Joseph A. Witter, M.D.	x	x	x	x	x
Richard E. Wunsch, M.D.	x	x	x	x	x
William J. Yott, M.D.	x	x	x	x	x
WEXFORD-MISSAUKEE					
Gregory P. Moore, M.D.	x	x	x	x	x

MEDICAL STUDENTS

UNIVERSITY OF MICHIGAN					
John Balog	x	x	x	x	x
Pat Carrier	x	x	x	–	–
David Drew	x	x	x	x	–
John Sikorski	x	x	x	–	x
David Tubergen	–	x	x	x	–
WAYNE STATE UNIVERSITY					
Drake Duane	x	–	–	–	x
Steve Georgiou	x	x	x	–	–
Bruce Kyburz	x	x	–	–	x
Joseph Liioi	–	–	–	x	–
John C. Rienstra	x	x	–	–	–
Fred Salamon	x	x	–	–	–
Thomas Schenk	x	x	x	–	x

II. IN MEMORIAM

[The assembly arose.]

THE VICE SPEAKER: The following former members of the House of Delegates have died during 1960:

Bay County:

F. H. Drummond, M.D.
Kawkawlin, Mich.
(Delegate 1941-42-43-44)
(Alternate 1940)

Branch County:

R. L. Wade, M.D.
Coldwater, Mich.
(Delegate 1937 through 1950)

Gratiot-Isabella-Clare County:

Charles F. DuBois, M.D.
Alma, Mich.
(Delegate 1938)

Oakland County:

Leon F. Cobb, M.D.
Pontiac, Mich.
(Alternate 1944)

Wayne County:

Robert E. Anslow, M.D.
Detroit, Mich.
(Alternate 1945)
Osborne A. Brines, M.D.
Detroit, Mich.
(Delegate 1950-51-52-53)
Edgar A. Bicknell, M.D.
Detroit, Mich.
(Alternate 1954-55)
V. George Chabut, M.D.
Northville, Mich.
(Alternate 1951-54-56)
William Hamilton, M.D.
Detroit, Mich.
(Alternate 1940-41-43)
John A. Hookey, M.D.
Wyandotte, Mich.
(Delegate 1937-38)
John H. Schlemmer, M.D.
Detroit, Mich.
(Delegate 1950-52-53-54)
(Alternate 1951)
Ward F. Seeley, M.D.
Detroit, Mich.
(Delegate 1946-47-48)
(Alternate 1945)
William P. Woodworth, M.D.
Detroit, Mich.
(Alternate 1937-38-40-41-42-43-44-45)

III. SPEAKER'S REMARKS

By J. J. Lightbody, M.D., Detroit

Your Speaker welcomes you to the 1960 Annual Session of the House of Delegates. This welcome is extended not only to the Delegates, Alternates and Officers of the Michigan State Medical Society, but to our many guests and members of the press, radio and television.

Two of our guests are Mrs. Harold Gay, President of the Woman's Auxiliary and Mrs. Reta Stahl, President of the Michigan State Medical Assistants Society—both of whom will be giving direct reports to you later this evening.

In addition, the Deans of both of our State Medical Schools, Dean Hubbard of the University of Michigan and Dean Scott of Wayne State University, have accepted invitations to be present at this session of the House.

This year again we will have as our guests junior and senior student representatives of our two medical schools, totaling twelve students, and each of these students have been assigned to a Reference Committee. They can feel however, that they have complete freedom of movement and may attend any of the Reference Committee meetings. These medical students will be formally introduced to the delegates at one of our meetings tomorrow.

The State of Michigan was honored this year by the election of Mrs. William Mackersie to the presidency of the Woman's Auxiliary of the American Medical Association. Mrs. Mackersie was invited to this meeting tonight to receive congratulations of this House of Delegates but because of an important previous official commitment in Seattle, Wash., she will not be able to be with us until later this week.

I wish to welcome also our friends and representatives from National Blue Shield, Dr. Donald H. Stubbs, Dr. Russell B. Carson, and John B. Castellucci, all of whom have been of such great help to us during the past year and working closely with our House of Delegates Committee.

The further remarks of the Speaker will be confined to the mechanics and functions of the House of Delegates. I hope that all members of the Michigan State Medical Society at this session will avail themselves of the opportunity to appear before the various Reference Committees tomorrow and Tuesday. Do not hesitate to make yourself known and heard on matters being considered by these committees.

This year for the first time we are trying out the use and value of a loose-leaf notebook and if you find them satisfactory the plan may be continued by subsequent Speakers.

In a letter to each delegate, alternate delegate and secretary of county medical societies from the Speaker dated August 10, you were asked to submit resolutions as soon as possible so that they could be printed and placed in your notebooks prior to the first meeting of the House.

This was to facilitate and expedite the handling and printing of these resolutions and to give the delegates more time to study them before being considered by the Reference Committees.

All of the resolutions that we have received to this date have been printed, numbered and placed in your notebooks. Each of these resolutions however, must be presented verbally to the House by a delegate, and after the reading of the resolutions, it will be referred to a Reference Committee. This means that the resolutions that have already been submitted do not have to be presented in triplicate at the time of the reading of the resolution. Any new resolutions however, which have not been submitted to this date must be submitted in the usual, traditional manner by a delegate reading the resolution and then presenting three printed copies to the Secretary, Dr. Wiley, who will then place it in the official file of the proper Reference Committee. Each Reference Committee has an official file for the resolutions and other materials that have been referred to the committee and the Chairman of each Reference Committee will be sure to obtain this file from the Secretary at the end of tomorrow morning's session following the introduction of resolutions.

I expect some degree of confusion resulting from this new method of presenting resolutions, but we will attempt to iron out the difficulties as they arise.

Please remember that any new resolution having to do with amendments to the Constitution must be laid over for one year, and that any proposed changes in the Bylaws must be considered at any subsequent meeting of the House. To amend the Constitution takes a two-thirds vote of the delegates seated and to amend the Bylaws takes only a majority vote.

In addressing the chair, use the nearest microphone and after you have been recognized by the chair, announce clearly your name and your county society name, so that the stenotypist and all delegates will know who you are.

The biographies of the three physicians who have been nominated for Michigan's Foremost Family Physician will be found in your notebooks and the delegates will choose one of these three by ballot tomorrow morning. There will be no formal reading of these biographies from the rostrum at the time of the voting, but any delegate or officer has the privilege of making a campaign speech for any one of the three nominees. Please read the biographies of these three distinguished men of medicine so that when the ballot is called, you may vote promptly.

A Press Committee has been appointed for the purpose of presenting newsworthy action of the House of Delegates to the public. Please allow the Press Committee to have this privilege; a member of the Committee will be in the press room at all times.

Your Speaker and Vice Speaker are available to the House for whatever help we may be able to give and we will attempt to conduct the meetings of the House in the forthright, efficient manner to which the delegates have been accustomed under the leadership of many previous distinguished Speakers. We will aim for courteous and proper consideration of all who wish to speak and will try to abide by the principles of recognized parliamentary procedure.

We are sure that your deliberations will result in a firm conviction that your time and labor have been well spent and that you have made a personal contribution to the health of the people of this great State of Michigan.

The Vice Speaker: This report will be sent to the Committee on Officers Reports.

[Applause]

IV. PRESIDENT'S REMARKS

By Milton A. Darling, M.D., Detroit

The Michigan State Medical Society is both a dynamic and a democratic organization. Its membership has doubled in twenty-five years. It publishes one of the outstanding scientific journals of its kind. Its progressive policies are duly recognized in the Councils of the American Medical Association.

At each annual session you gentlemen of the House of Delegates comprise the legislative body of the Michigan State Medical Society, translating into action the instructions of your constituents. Immediately following adjournment, your officers and the Council develop the necessary procedures to inaugurate your instructions. What organization could be more democratic?

Protocol requires the President to address the House of Delegates. For the sake of brevity he will omit reference to the multitudinous activities of your Society, important as they are, and direct your particular attention to some salient subjects which in his opinion, require the serious consideration of this body.

Medical Education

The Michigan State Medical Society is most fortunate in having liaison and a close cooperation between our two State Medical Schools. Both Deans attend the Council meetings as advisors when problems relating to undergraduate or postgraduate medical education are considered.

Times have changed the methods of medical teaching. Today we delegate basic teaching to the universities and their colleges of medicine. While the preceptor-student relationship of our forefathers no longer exists, this does not relieve the medical profession of its responsibility, for medical training must remain closely associated with the practice of medicine. Organized medicine has maintained its partnership with the medical schools by setting up standards of ethical practice, continuing graduate education and recruitment of medical students.

And now, Mr. Speaker, and members of the House of Delegates, I beg your earnest consideration of this question of recruitment of medical students. It may come as a shock to some of you to realize that during the past ten years there has been a decrease of more than 24,000 applications for enrollment in the medical colleges of the United States and Canada; 7000 fewer students sought entrance to medical schools in 1959-1960 than in 1950-1951.

The facts are, that too frequently the best talented high school boys and girls are not seeking medicine as a vocation but are choosing other professions. Many reasons have been given for this shift, such as medicine's prolonged and costly education, the fear of socialized medicine, the sudden interest in outer space with renewed interest in chemistry and electronics. Whatever the reason, it is our job, yours and mine, to reverse this trend.

It is evident that the United States with its rapidly expanding population will require an increased number of physicians if the traditional ratio between physician and population is to be maintained. The Medical Schools of Michigan need our help. They are admitting 325 students each year. But the problem is not how many physicians our schools graduate but how many remain in practice in Michigan. Paradoxically, about one-half of Michigan's practicing physicians receive their medical training outside the state and only about half of our graduates remain in the state to practice. Why do 50% of our graduates leave Michigan to establish practice elsewhere? Are we so busy with our own problems that we fail to inculcate in our interns and residents the high professional standards we profess to set for ourselves?

Whatever the reason, it is obvious a re-evaluation is greatly needed. While we encourage the acquisition of physicians from other state medical schools we should be able to retain a larger percentage of our own alumni.

Too much emphasis cannot be put on the subject which has become such a serious matter. Recruiting of promising students for a medical career is our most urgent business. If we fail to continue to provide the public with adequate high quality medical care we have no alibi if some agency of Government attempts to do it for us.

Mr. Speaker, your President recommends that every component county society officially sponsor and actively sustain "A Teen-Age M.D. Club," with the avowed purpose of interesting more eligible qualified students to pursue the study of medicine.

Michigan Medical Service

During the past year your President has been invited to attend Michigan Medical Service Board meetings as an observer. He is deeply impressed with the sacrifice of vital time representing thousands of man-hours, as well as the serious approach of board members endeavoring to solve the problems of Blue Shield. Michigan Medical Service is "Big Business" involving half the population of Michigan. It constantly sails into troubled waters, buffeted by currents of subscriber requests, demands of the medical profession and restrictions imposed by the enabling act, as well as the regulations of the Michigan Insurance Department. It must move cautiously in order to maintain its course on an even keel. When policy changes are contemplated, an unbelievable amount of study and analysis is required. Legal aspects, sales resistance, rate structure and actuarial factors must be considered. Changes must be made as necessity arises, but they cannot be made instantly, upon passage of a resolution. This House of Delegates, sitting as a corporation, is strongly urged to give due consideration to this matter and thereby allow management a reasonable moratorium in instituting revisions of policy.

Cancer

Last year the House of Delegates deleted the Cancer Committee of the Michigan State Medical Society, believing the field of cancer could be covered by the Michigan Cancer Coordinating Committee, a group formed in 1953 representing all Michigan agencies primarily interested in cancer control—including five Michigan State Medical Society representatives. However, experience has convinced the Council of the Michigan State Medical Society that the Cancer Control Committee of this Society should be reactivated to give greater strength to the over-all cancer movement in Michigan. Therefore, Mr. Speaker and Gentlemen of the House of Delegates, your President recommends the re-creation of the Cancer Control Committee of the Michigan State Medical Society.

Finance

The question of the disposition of funds of the Michigan State Medical Society is constantly being raised. At the January annual meeting of the Council, the budget for the ensuing year is most meticulously analyzed. In addition the Finance Committee reviews the entire situation each month, thereby assuring the members of the Michigan State Medical Society that no unwarranted expense occurs. In 1959 your president-elect in his address to the House of Delegates said, "Any member of this Society is not only privileged but is urged to make inquiry about any matter of which he is in doubt."

The House of Delegates authorized the construction of a vitally needed Michigan State Medical Society headquarters building. This structure, after unavoidable delays, is nearing completion. It is imposing in appearance, utilitarian in design and conveniently located, and should prove a source of pride to every member of the Society. However, it has been built in a time of rising prices and its cost, including land and furnishings, will approximate $724,000. Arrangements have been made for an unsecured loan of $300,000, which will be required for completion of the building.

Two unknown factors immediately inject themselves, viz.: The added costs of taxation and maintenance. In the absence of experience, only estimates can be utilized. When the sale of our 606 Townsend Street, Lansing property is consummated, the amount should about offset the cost of the new land in East Lansing.

The special allocation of $15 per member, per year, should amortize the loan in six years. However, by action of the House of Delegates, the allocation is not levied after 1961, leaving dues as the Society's only source of revenue after 1961. Obviously, the present rate of dues would be inadequate to meet the Society's budget requirements so it will function and at the same time amortize its indebtedness.

Your attention should be invited to providing adequate funds to meet emergencies such as the recent "crash program" to aid in defeating Forand-type legislation, which proved most effective. The avalanche of protests from the "grass roots" directed to the Halls of Congress, had a most salutory effect in stiffening resistance to pending medical legislation tied to Social Security. Both political parties have indicated they will press for additional legislation in the coming session. Consequently, we should be prepared financially to marshal our forces with renewed vigor.

In essence, our financial picture differs little from similar organizations—except for capital expenses in the new building—in meeting rising costs and adequately compensating valued employees.

Further and more detailed information on the financial structure will be submitted to you by the Big Look Committee and the House of Delegates' Committee to Review the Financial Structure of Michigan State Medical Society.

Mr. Speaker, and Members of the House of Delegates, your President urges you, after hearing all the evidence, to give serious consideration to the problem of providing adequate financial resources for the operation of your Society, and further, that you project your thinking to cover the foreseeable future and its need for financial resources to meet emergencies and opportunities for service which will come.

Doctors of medicine should take a greater interest in elections. The two great political parties have spelled out the mechanisms whereby each hopes to gain meritorius health goals. All of us are capable of analyzing the governmental mechanisms these platforms call for and the relationship of the legislation promised to our philosophy of what constitutes the part Government should play in the health field.

We can express our will by voting for the candidates—be they running for state or national office—that espouse the political methodologies that most closely approximate our wishes. We have a duty as doctors and citizens, not only to vote, but to urge our friends to vote. For us to fail to do both of these things will be tragic, indeed.

Your President has deeply appreciated the privilege afforded him of attending both national and out-of-state meetings with the knowledge and friendships gained thereby. He has been the recipient of unstinted loyalty and cooperation from all the officers, the Council, and the various committees, whose prodigious efforts make this organization a success. To the Executive Director and his staff, the Public Relations Director and his staff, as well as the Michigan State Medical Society secretary in the Detroit office, who have so ably served your Society, he owes a deep personal debt of gratitude. And to you, the members of the Michigan State Medical Society, go his heartfelt thanks for the privilege of representing you and for your loyal assistance through this past year. It has been an experience to be remembered and cherished always.

The Speaker: The President's remarks will be referred to the Reference Committee on Officers Reports.

V. PRESIDENT-ELECT'S REMARKS

By Kenneth H. Johnson, M.D., Lansing

Just as it is a great privilege to serve as one of your presiding officers for five years, so it has been a very real privilege to be busy in similar service to Michigan medicine as President-elect during this past year. I am most grateful for the opportunity, sincerely hoping that I may have contributed something worth while to this great Society. I expect to be busier next year.

My very first wish before this House today is to pay personal tribute to a man whose quiet dignity, keen sense of humor and kindly and sage counsel have earned him the right to be called a wonderful President of the Michigan State Medical Society, Dr. Milton Darling of Wayne.

Secondly, I want to commend all of the Officers, Councilors, Chairmen and Members of Committees, the Woman's Auxiliary and the Medical Assistants Society and our industrious and most excellent office staff for untiring devotion to duty during the past year. I find words inadequate to express my feelings in this matter and will simply offer a personal "well done" to every one who has participated and suggest to this House that they all deserve your highest praise.

During the past six years I have had contacts with various individuals and groups representing labor, industry, farm interests, government, politics and politicians, Blue Shield-Blue Cross, organized medicine, hospitals, the general public, patients, students, lay health organizations, as well as with many, many physicians whom I have met in doctor's rooms and in a variety of hallways. I have listened to everyone, and have tried to sort out what was significant to Michigan medicine and the proper functioning of our profession in this state. I have watched for five years the serious businesslike way in which this House has been conducted, even when debate has been rough and tempers short. I have attended most meetings of the Council for the past five years and I know the attitude of serious contemplation which goes into its work to benefit Michigan medicine and the citizens of this state. I know, personally, of the serious devotion to their responsibilities evidenced by committees and their chairmen charged with the duty of coming up with an answer to specific problems.

I believe, however, and this belief has become more certain as time has progressed, that the profession of medicine must be totally unified behind the basic goal of its original purpose, the health and welfare of the public it serves. Any substantial threat to this unity of purpose—whether by dissidence within or by pressures from without—can lead only to one thing—weakening and dissolution of our profession. It is no longer enough that each physician take care of his "patients" and thereby believe that he has adequately fulfilled his job. We doctors may be individually loved by many of our patients, and we may be proud that to a great many people we are worthy of the position of importance we hold—but this fact cannot necessarily protect us from forces which could change us from a profession to something far less in due course of events. Only by justifying our existence as a profession, proving that we are worthy in a broad sense, can we hope to survive.

A couple of years ago, Dr. Fred Drolett who was the Michigan Foremost Family Physician, said to me, "Ken, I have witnessed the golden age of medicine, things will never be the same again." I cannot say whether Dr. Fred will be right or not, but of this I am sure, we can no longer leave the matter up to a few brilliant individuals to front for the rest of us. If we care that medicine should stand for an idealistic, esthetic, religious, practical belief that life is precious and that each person has a right to life in its fullest meaning, then we must not sacrifice this ideal through becoming involved in lesser works or lackadaisical in our concern for those we serve.

I should not wish to go into detail as to the matters which I see as either actual or potential threats to the ideal of which I speak, but should like to touch generally on several.

It is my opinion that any argument about the relative importance of a specialist over a generalist or a certain specialty over another specialty, which becomes aired in public, tends in the direction of destroying the confidence of laymen in the entire profession.

Opinions expressed by physicians which are not backed by facts leave a particularly unfortunate reaction in the minds of other physicians and laymen. We have been trained in objectivity in the treatment of illness, and the same objectivity is expected of us in dealing with other problems. There is little place for pure emotional reaction. Lack of communication has been sometimes blamed for problems in this area, but I feel that this is as often the result of failure to dig out the facts as it is due to a paucity of them.

Although it is important that we strive to settle our differences concerning the economic welfare of physicians in this state, particularly as regards Blue Shield, it would be a tragedy if we were to so exhaust ourselves that we had nothing left to carry out our basic responsibility—the health of the citizens of this state.

These are matters which I consider to be within our ability to control by our own determination as members of a dignified profession.

In addition, there are outside forces which tend to militate against our remaining a united profession. There is no question that certain political creeds, certain philosophies as presented by large and carefully integrated organizations, as well as certain so-called "authorities" who by their own admission know all the answers, have no concern whatever for the perpetuation of medicine as a profession. These elements of society see only their own ideas, their own programs, their own devices as being important without regard for the long-range effect. I believe that medicine must stand firm in opposition to these socio-economic trends which would destroy what we hold dear. I believe we should not only oppose these trends, but should also present programs which are positive in their intent and certain of their good effect.

Lest I seem to be assuming the mantle of a prophet of doom, let's look ahead to some ideas on which Michigan medicine may spend its energy and talent in good enterprise for the next few years.

We are today in East Lansing, gradually approaching completion of our new headquarters building. I believe, Mr. Speaker and members of this House of Delegates, that every doctor in Michigan will be proud of the final result. I am sure that each physician will agree that here we have a priceless architectural representation of the dignity of the profession of medicine in this state. There will be no need to seek it out on some side street, but it will stand many generations for all to see, a proud reminder that we Michigan physicians are moving forward and do not intend to maintain a condition of "status quo." But the structure itself is not enough—far more important is its functional value. It has been functionally designed, but only by using this new building to its fullest capacity may we completely consecrate its existence. This we must do.

Therefore with the dedication of our new headquarters this coming year, we are proposing a concentrated effort over the next five years to place the primary goal of our profession in the spot of pre-eminence where it belongs. We are presenting to you a plan which has been designated "The Presidents Program" which we trust will find wholehearted approval from this House of Delegates as a worthwhile project for the future. The proposal means to concentrate our energy, our mutual efforts, as doctors of medicine in this state, toward providing the citizens of Michigan five more good useful years of life by 1965—which is the year of the Society's centennial. There could be no finer birthday gift. This does not mean that we plan merely to increase life expectancy by five more years. Rather, we hope to increase our efforts in the various fields of health in which we are already engaged in order to offer every citizen a greater chance for a better, healthier span of life. It is easy to see how we may increase our efforts to improve neonatal care. It is not beyond the scope of this program to wipe out polio during this five years. We may also wish to become increasingly interested in doing a great deal more as a Society to cut down the terrible slaughter on our highways, and most certainly we intend to promote our ideas towards better health and happiness for our senior citizens.

Could there be a better program for Michigan medicine to begin this year? Your Council has enthusiastically approved it. Implementing resolutions will be presented to this House to study and we hope you adopt them. I feel that you will obtain a more detailed picture of this plan in this way than I can present in further words at this time.

In the implementation of this program, I see a golden opportunity to achieve several things. Here is a program which cannot help but allow every physician in Michigan a chance to participate, a unification of purpose. Here we have the great chance to establish our new headquarters as the functional center for this unified purpose. Here we have the chance to come into direct contact with the public through groups which we trust will assist in this idea. Many of them are already interested in the field of health in some way. Many others will be invited by Michigan State Medical Society to give leadership. Finally, here we have a great opportunity to provide a singular achievement of improved health and happiness for this state and its citizens, worthy to celebrate when the Michigan State Medical Society proclaims 100 years of existence five years from now.

I present this idea to you with sincere expectation that this House will enthusiastically approve of it. I trust to see you all at the dedication of our new headquarters in East Lansing next June and in 1965 when we shall celebrate our centennial in Detroit where the Michigan State Medical Society was formed.

The Speaker: Dr. Johnson's remarks will be referred to the Reference Committee on Officers Reports.

VI. REPORTS OF THE COUNCIL

By H. J. Meier, M.D., Coldwater

Delegates of the Michigan State Medical Society, as Chairman of your Council, I would like to present the annual report of this body, its deliberations, actions, and in broad terms, the entire scope of activities of the Michigan State Medical Society for the fiscal year 1960.

The annual report of The Council appears in the Delegate's Handbook beginning on page 51. It has been compiled categorically in sections for clarity and simplicity. To save the time of the House of Delegates Reference Committee the Annual Reports of Committees of the Council are integrated into this Annual Report of The Council.

You have all been apprised of the activities of The Council throughout the year as printed in the Handbook, in your Councilor District meetings prior to the Annual Session, and many of you have been receiving full Council meeting minutes each month so this House should be the best informed of any to date.

I call particular attention to matters referred for action by the 1959 House of Delegates beginning on page 78, and the Recommendations of The Council, beginning on page 82.

This evening I shall just give you a synopsis of activities, an overview as it were of the MSMS during the year. Following this you will hear the Supplemental Report of The Council from July 1 to date.

The main points in the printed Annual Report of The Council that I am going to outline are these: Postgraduate medical education, medical care of the aged, and the cost of conducting your Society business. I would also like to mention the complex network of liaison among voluntary organizations and governmental agencies which directly affect you and your medical practice. In addition, we shall consider the results of the many hours all of us have spent in the past year in contributing to the solution of numerous scientific and socio-economic problems discussed during the 110 MSMS committee meetings held in 1960. Then, finally, there is the brand-new program—the Presidents Program—to place medicine in its deserved position of dynamic leadership. In the Presidents Program doctors will direct, in cooperation with all interested public groups, the promotion of health and the adding of five good useful years of life to all people of Michigan by the Centennial Anniversary of MSMS in 1965.

Now let's take up these points one at a time.

First scientific postgraduate medical education.

Two of the most widely known postgraduate refresher courses are the MSMS Annual Session and the Michigan Clinical Institute. More than 4500 M.D.'s attend these central meetings. In addition, the MSMS extramural teaching program reaches out into eleven regions of Michigan to practicing doctors in their home communities. And each month the Journal of MSMS is on the desk of every member to make sure that the newest scientific advances and the latest socio-economic news are available to every M.D. in practice.

Our second point is medical care of the aged.

Other than the direction of the scientific programs, no other activity was as demanding as that of the question

of medical care of the aged during the past nine months.

Medicine has long been accused of being against everything and never for anything. Well, this year the Michigan State Medical Society was for a workable solution to the problems of the aging. On April 3, the MSMS Workshop on Problems of the Aging was held in Kellogg Center, East Lansing, attended by representatives from Government, social welfare, hospitals, medical societies and committee members, and so forth. Out of this meeting came a ten point program—a positive program—which medicine believed and still believes is the answer to the needs of our senior citizens.

The essence of that ten point program is as follows:

Remove compulsory retirement restrictions.
Develop pre-retirement planning at age 45.
Encourage work opportunities.
Let local Governments share cost of voluntary health insurance.
Increase cash benefits to those receiving welfare payments under Old Age Assistance.
Include the near-needy under Old Age Assistance programs.
Guarantee health insurance premium payments through a Federal-Deposit-Insurance-Corporation-type plan.
Investigate the real needs of the aging through scientific study.
Participate in the state and national aging conferences.
Emphasize a preventive medicine program.

Positive action was taken on the 10-point program, through the MSMS Campaign for Freedom. The campaign was a strategic attack by doctors and their patients on Forand-type legislation. The strength of the attack can perhaps be measured by the fact that nearly 300,000 pamphlets called "A Question of Freedom," produced by our Public Relations Department, were distributed by doctors who were hep to the situation. Just think what we could have done if all doctors had participated, rather than just half of our membership.

You all know what finally happened, the Forand Bill was defeated and the Mills Bill was signed into law by the President. The Mills Bill, of course, followed our approach to the problem. Even though this skirmish has been won, it's only a skirmish, the big battle is upon us in this presidential election and in the next congressional session. Since the writing of this report, events have occurred that prompted The Council to further consideration of the problem.

Next, let's consider finances.

The medical profession can be a powerful force, but to make it so is an expensive proposition. The printing cost alone of the pamphlets some of us distributed against Forand was $5800. But this is only the beginning. They had to be mailed and processed and promoted to make sure that they would be used most effectively. Now you may not think this is a major item or one that is deserving to eke this amount out of a carefully planned budget. This same sincere concern is evidenced in every financial authorization. The Michigan State Medical Society is big business and has a responsibility to the profession to act as a big business.

The business of the Society is every doctor's business and a detailed financial report for the period ending June 30 is contained in your handbook. In the second part of my presentation I will attempt to bring you up to date on the financial picture of MSMS as of this month.

Now let's consider some of the important things your Society did in the complex network of liaison among voluntary organizations and governmental agencies. To begin with, representatives of MSMS previewed the University of Michigan Study of Medical and Hospital Economics. This study, which was requested by your Society, was financed by the Kellogg Foundation at a cost of $380,000.

Other members of the Society appeared at the Michigan Insurance Commissioner's public hearing on a proposed Blue Shield rate increase. These hearings were held in Detroit and Grand Rapids. MSMS took a positive public stand in support of the increase, and at the same time, defended itself against charges by public critics.

In addition, your Society

Established liaison with our three major state universities regarding future medical education needs.

Participated in the eleven Regional Aging Conferences, the State Conference on Aging, the McNamara Hearings, and will have delegates to the 1961 White House Conference on Aging.

Took part in the White House Conference on Children and Youth.

Revised the Michigan Uniform Fee Schedule for Governmental Welfare Agencies, the first since 1949.

Objected to the lack of scientific viewpoint in the Kefauver Drug hearings.

Expressed the view that a proposal to substitute the generic names for brand names in drug prescriptions was unnecessary.

Beneficial contacts with other governmental agencies were also carried out with the Michigan Legislature and the Federal Congress, the Michigan Department of Health, the Department of Public Instruction and Vocational Rehabilitation, Department of Social Welfare and the State Board of Registration in Medicine.

Turning to the committee activities within our Society, as I've mentioned, 110 committee meetings were held. The minutes of these meetings are all mimeographed in advance and distributed to members of The Council for study before they are officially presented to the next meeting of the full Council. The recommendations of the committees represent a tremendous amount of time and study on the part of members of committees and The Council, and I'm sure this House of Delegates appreciates the interested effort contributed by these several hundred workmen. Modest annual reports of the committee activities are contained in your handbook.

As for the presidential program, Dr. Kenneth H. Johnson has already detailed its elements. It promotes the concept that five more useful years can be added to the working life of the people if medicine takes leadership and enlists the cooperation of all of the Michigan public.

Supplemental Report

Now I would like to present to you the Supplemental Report of The Council which embodies the developments, activities and up to date account of actions since the printing of the handbook in July.

Membership

On September 1, 1960, the membership of the Michigan State Medical Society totaled 6673 as compared with the total of 6638 at the same time last year.

Finances

FINANCIAL REPORT FOR PERIOD ENDING AUGUST 31, 1960

Account	On Hand 12/1/59	Income to 9/1/60	Expenses to 9/1/60	Balance on Hand 9/1/60
General Fund ($23,125.00 to New Hdqts. Fund)	$128,908.93	$157,830.87	$155,849.26	$130,890.54
Annual Session	———	26,182.53	5,600.67	20,581.86
Michigan Clinical Institute	———	14,215.00	14,040.32	174.68
The Journal	———	101,911.21	101,386.83	524.38
Public Education	34,651.34	53,932.16	36,061.56	52,521.94
Public Service	8,683.54Cr.	26,152.70	10,846.62	6,622.54
Professional Relations	9,134.49Cr.	36,304.29	25,308.75	1,861.05
Public Education Reserve ($15,000.00 to Campaign for Freedom)	35,000.00	———	———	35,000.00
Rheumatic Fever Control	3,275.12	2,180.67	2,976.27	2,479.52
Contingent Fund	———	8,679.83	———	8,679.83
Building Fund	4,936.60	———	3,126.88	1,809.72
MSMS Headquarters Fund	148,313.04	91,785.75	178,680.92	61,417.87
New Hdqts. Under Construction (Equity)	159,334.14	178,680.92	———	338,015.06
	$496,601.14	$697,855.93	$533,878.08	$660,578.99

It is listed in the same method as in your handbook. I would like to have you glance at the bottom of that table and refer you to the figure, the last item, which in your handbook states the balance on hand of $721,546.78. That now stands as $660,578.99. I would like to call to your attention that this is not actually a balance on hand. It is a tabulation of our assets, and Mr. Speaker, I would like to call on Dr. McGillicuddy, the Chairman of the Finance Committee, now, to give you in capsule form exactly what that amount of money amounts to, where it is, and what we can do about it.

Report of Finance Chairman O. B. McGillicuddy, M.D.

As the Council Chairman stated, the current total assets on the 31st of August were $660,578.99. I am not going to go into full explanation of our finances. This is going to be handled, and very capably by Dr. Engelke's Committee Report which is in the very front part of your folder. When this report has been given and referred to a Reference Committee, if there are any questions—and I am sure there will be—I hope there will be many questions, the Finance Chairman, the Treasurer, the Auditor and Dr. Engelke and his committee or some of them, at least, will be present to answer any and all questions.

Tonight, to save time, I merely want to point out to you where this money is, this $660,000.00 I have about eight items here.

If you want to take a pencil out and write them down, I will give you the round figures so that you can be contemplating because I think they will help you to understand Dr. Engelke's report.

$34,500-plus dollars are in the checking, savings and petty cash.

We carry the building at 606 Townsend, the old headquarters, on our books at $48,000. We are trying to sell it for $65,000, but to date we haven't had any takers, so the figure $48,000 is carried on our books as its value.

We have invested and paid at this moment, in the new headquarters, including the land and that part of the building which is finished, $404,000.

We have in accounts receivable $16,000-plus. We had in bonds as of August 31, $156,566.00. I might explain at this moment that we are maintaining a reserve in the general fund for emergencies of $50,000 which is part of these bonds. We also set up in the public relations account another $50,000 which is another $50,000 which is part of these bonds. Of that amount the public relations people have sent $11,000 on the Campaign for Freedom and are contemplating spending more, so that is the bond situation.

Then we have due from the employes on the employe pension and trust fund—this is a figure which will be paid back to us by the end of the year, $1600.00. These added together give you the figure of our net worth of $660,000-plus.

It is perfectly obvious—we haven't the cash as yet for the building. We hope to have it soon from the older building at 606 Townsend. That $404,000 we have in the new building is not available cash. A large part of the bonds are being maintained in a reserve which we feel is necessary, so this brings you down to a realistic figure of how much available cash we have on hand.

As I said, any questions will be answered at the Reference Committee. I want to take this opportunity to congratulate Dr. Engelke and his committee on a wonderful job well done.

If you will take the time to read their report, you will agree with me. I haven't had a chance to speak to him since I received this report. I want to take this opportunity to make one correction. On Page 20 of his report he states the following:

"Dr. McGillicuddy and the committee discussed the current financial situation of the Michigan State Medical Society and advised the committee members of his philosophy and the need for economy and necessary borrowing in 1960 to complete the new MSMS headquarters building now under construction"

This is correct, and I agree with it, but then he goes on to say:

"and to finance the anticipated deficit in the general Society's operations for the current year and future years."

And this is not part of my philosophy as I have stated to The Council over and over again. I do not feel that we can ask any lending institution to lend us money to run our Society, so that any deficits that we have this year or next will be handled so far as possible, I assure you, out of our own reserves.

REPORTS OF THE COUNCIL (Continued)

H. J. Meier, M.D.: Now as to Michigan Medical Service.

An up to date report of this corporation, including finances will be presented to you at the meeting of the Michigan Medical Service Membership on Tuesday, September 27, 1960, at 2:00 p.m., in the English Room of the Sheraton-Cadillac Hotel, Detroit. All MSMS delegates are members of Michigan Medical Service Corporation and are expected and urged to attend this important annual meeting, which will be preceded at 12:30 p.m., by a reception and luncheon with the compliments of Michigan Medical Service.

Michigan's Foremost Family Physician of 1960

Selection of one of our Michigan general practitioners as nominee for the AMA Gold Medal Award is the privilege of the MSMS House of Delegates. According to established procedure, the field of nominees has been narrowed by The Council to three, from which the House of Delegates elects one. The three nominees are:

1. Colin D. Munro, M.D., Jackson
2. George P. Raynale, M.D., Birmingham
3. Edwin L. Thirlby, M.D., Traverse City

MSMS Group Insurance Programs

a) Group Life Plan.

The supplemental report to August 30, 1960, supplied by the carrier—Mutual Benefit Life Insurance Co., of New Jersey—indicates that the total of subscribers is 1470—an increase of 320 in one year—with $13,033,500 volume of insurance in force. Twenty-two death claims amounting to $127,500 have been paid. Conversions to permanent insurance have been made on twenty-one lives in the amount of $68,500.

b) Group Health and Accident Plan.

The report to September 1, 1960, supplied by the carrier—Provident Life and Accident Insurance Co., of Chattanooga, Tenn.—is as follows:

Currently there are 2073 members insured. During the past year 530 payments were made to 231 members. In other words, more than 10% of those insured received a payment under the group plan during the last twelve months. The payments come out to average of about $45.00 each month.

At present there are thirty open claims upon which periodic payments are being made because of continuing disability. The average thus far for each of these cases is in excess of $2200.00.

Each claim payment made since November 15, 1959, has been increased by 10% over the amount called for in the policy contract because of the claim bonus. Due to our increased participation and the excellent cooperation of the Michigan State Medical Society, Provident looks forward to the continuance of the claim bonus for the coming policy year beginning November 15, 1960.

New Headquarters Building of Michigan State Medical Society

Two labor strikes—the steel and the ironworkers—held up construction on our building. However, since

the middle of June, rapid progress is being made by the contractors and the building is taking shape and should be ready for occupancy shortly after the first of the year. The new MSMS building of 20,000 square feet will be dignified, imposing, and a modern structure of which every MSMS member will be truly proud. Besides, it will be extremely functional in operation. The Big Look Committee wishes to present up to date details on the new building in its supplemental report. I, therefore, respectfully request, Mr. Speaker, and Members of the House of Delegates, that you grant Dr. K. H. Johnson, a member of this committee a few minutes to give you a current summary on your new building in East Lansing.

Supplemental Annual Report of Big Look Committee 1959-1960

K. H. Johnson, M.D.: Mr. Chairman, Mr. Speaker, I am filling in for Chairman W. S. Jones, M.D., of Menominee who is unable to be here tonight.

1. Your committee wishes to report that after two general work stoppages—steel strike and ironworkers strike—which delayed building progress for several months, the contractors are now busy at work on the new MSMS headquarters building in East Lansing. The present progress would indicate that the building will be ready for occupancy in February. Official dedication of the building is scheduled for June 1961.

Last year your Committee on Big Look reported that the building would cost $602,295.87 exclusive of land and furnishings. This figure, approved by the 1959 House of Delegates has stood up, despite a small percentage representing necessary change orders.

The land—three acres—was purchased for $65,146.00 —a reasonable price in view of its unusually excellent location.

The furnishings, being coordinated under the supervision of Architect M. Yamasaki and Associates, are estimated not to exceed The Council-approved budget of $64,144.00, but this total is reduced to about $57,000.00 net through private gifts—such as from the Past Presidents, the Woman's Auxiliary, Bruce Publishing Company.

The total estimated cost of the building, therefore, will be $724,441.87. This represents our committee's 1959 estimate of $602,295.87 plus costs of the furnishings and the land.

Since the net cost of the building is $549,771.18 it should be invited to your attention that we are erecting this edifice of great permanence for the reasonable square foot price of $27.48. This is not out of line with other buildings such as the new State Bar Building in Lansing. Your committee feels that this building obviates any necessity for any addition for years to come.

2. The MSMS property at 606 Townsend is being listed by forty Lansing realtors, and the sales price is offered at $65,000.00. This price is expected to offset the cost of the new land in East Lansing.

All facets of the work of the Big Look Committee have been officially approved by the House of Delegates, except the matter of furnishings. Therefore, the Committee on Big Look requests approval of the cost of furnishing the new building so that when the contractors complete their work in November or December, the decorators may immediately proceed with finishing the job so the building may be utilized beginning February 1961.

Your Committee on Big Look appreciates the confidence that has been placed in it in connection with erecting the new MSMS headquarters building. It has been a tremendous task, filled with day-to-day problems, with an extra burden of work on The Council and executive staff. The Chairman of the Big Look Committee wishes to express his thanks to all, especially the members of his own Big Look Committee for devotion to this big task, far beyond the call of duty.

Respectfully submitted,
W. S. Jones, M.D., *Chairman*
Milton A. Darling, M.D.
W. A. Hyland, M.D.
K. H. Johnson, M.D.
O. B. McGillicuddy, M.D.
G. B. Saltonstall, M.D.

REPORTS OF THE COUNCIL (Continued)

Councilor Changes

H. J. Meier, M.D.:

a) C. N. Hoyt, M.D., Councilor of the 7th District, resigned effective September 25 in order to take up postgraduate work in Detroit. The Council placed on its minutes a vote of high thanks to Dr. Hoyt for his service to the Society.

b) B. T. Montgomery, M.D., Councilor of the 12th District, also resigned as of September 25 due to the pressure of his other activities. Dr. Montgomery brilliantly served many years in various posts of the Michigan State Medical Society and as Councilor.

c) D. G. Pike, M.D., also resigned as of today, September 25, to take postgraduate work in Washington, D. C., in otolaryngology.

The counsel and the friendship of all of these men will be seriously missed.

Additional Annual Reports of Committees of The Council

Before we present additional reports of committees of The Council, we beg leave of the House of Delegates to give J. W. Rice, M.D., Chairman of the Medical Care Insurance Committee, the opportunity to present the Supplemental Annual Report of his committee. This group recently held most important conferences with labor, management and specialty groups and we feel a report on these meetings should be presented to the delegates as a separate item of business. Mr. Speaker and Members of the House of Delegates, I hope that you will grant Dr. Rice the floor, to inform on the recent transactions of his committee.

Supplemental Annual Report of the MSMS Medical Care Insurance Committee By J. W. Rice, M.D.

This report covers:

I. The proposed $6500 contract
II. Its effect upon
 A. Subscribers
 B. Employers
 C. Physicians
III. Committee recommendations

One year ago the House of Delegates of the Michigan State Medical Society passed resolutions that:

1. The basis for service contracts be determined on total family income.
2. As soon as feasible, the maximum total family income for service contracts be established at $6500.00
3. The present status of service contracts including the sale of existing contracts be continued until such time as these changes are satisfactorily implemented.
4. The Board of Directors of Michigan Medical Service be informed of these changes in policy and be requested to proceed with their implementation forthwith.

In the past year, the Michigan Medical Service enrollment committee and staff have prepared a basic $6500 family income contract to comply with the 1959 House of Delegates resolutions. The basic coverage is:

1. Surgery in the hospital
2. Obstetrics
3. Anesthesia
4. In-hospital medical care for 30 days
5. Emergency first aid

In addition other services which are not in M-75 would be available by optional riders.

These other services outside of the basic contract would be:

1. In-hospital medical care for 70, 120, 365 days
2. Radiological diagnostic services
3. Radiological therapeutic services
4. Diagnostic services such as EKG, EEG, laboratory tests in office of physician or as outpatient in hospital
5. Consultation services
6. Technical surgical assistance

The $6500 contract is intended to be flexible and to give the consumer a wide range of choice in selection of a prepayment insurance package. Fees to physicians under this $6500 contract will have to be reduced some 15% from the M-75 schedule for all plans because of the change from certified single subscriber income determination to a family income determination. In addition, plans C and D will be reduced another 4% because the service ceiling is dropped from $7500 to $6500, therefore reducing the benefits.

To summarize, the $6500 family income contract will present:

1. A complex arrangement of basic contract plus riders, which would give the consumers many choices, but would be bewildering to the average individual.

2. The physician giving the service now would have the job of determining the family income. He must require the patient to certify his total family income and then compare this stated family income with the contract in his possession. In those cases where the total family income is above the contract ceiling, i.e., $2500, $5000 or $6500 the physician may make an additional charge.

3. The fee schedule will be reduced about 15 to 19 per cent. This the physician must accept, unless he can demonstrate that the patient's family income is above the limits of the contract in his possession; he can then make an additional charge.

In considering the proposed change in M-75 to a $6500 family income contract, the committee asks that you examine with us the effect upon:

1. The 3.5 million Michigan residents dependent upon Blue Shield for medical and economic security.

2. The employer, who directly or indirectly foots the bill.

3. The doctors of Michigan who supply the service.

A. The Effect upon the Subscribers:

First, let us deal with the three and one-half million people dependent in Michigan on Blue Shield for medical care:

To determine the possible reception to the change, the Medical Care Insurance Committee held conferences with officials of the Detroit Public Schools, General Motors Corporation, UAW-CIO, City of Detroit, and the Ford Motor Company. Detailed summaries of the committee conferences with each of these consumer groups have been presented to the MSMS Council. The MCIC also recommends that copies be made available to all members of the 1960 House of Delegates.

Gentlemen, there is a lot of detailed information in those reports that we boiled down in a supplemental report. The supplemental report contains only a small fraction of what is in the reports outside. I would advise you all to read them carefully because we have information in there that is pertinent to the problem.

Questions raised with each group included: Do your employes like M-75? Do you have many complaints against M-75? Do you like the comprehensive package or would you prefer riders? How will the employes react to a change in income determination for service coverage? How will they react to change in income ceiling from $7500 to $6500?

Let us briefly tell you how each of the groups answered such questions:

City of Detroit, with 14,500 employes covered:

Please make the contract as simple as possible. We don't want complicated contracts for our workers. The family income arrangement would be difficult for us to explain and for the workers to understand. They like to present their income certified card and not have to pay extra. The city workers like M-75. We have few complaints.

Ford Motor Company, with 80,000 hourly workers and salaried employes covered:

It would be a grave mistake to abandon M-75. Ford likes M-75 and so do the workers. Ford's main concern is to provide service benefits to serve substantially all 50,000 hourly workers. To place riders on a basic program would cause both administrative and enrollment problems. At present, Ford seeks to support a "standard" package plan. It would be a question if Ford would want to make all the different options available. The offering of many alternatives seems an unduly complex way of providing service benefits. If Ford has to go to an indemnity program, then we would look for the best possible indemnity plan—which might be adverse to doctors in general.

Detroit Public Schools, with 5500 covered by Blue Shield:

The employes would regret very much a shift from M-75 to M-65. Family income as the determination for service would be difficult to understand. It would be difficult for the subscribers to understand why the "ground rules" need to be changed. There would be many complaints. It has taken many years to build up interest among the teachers in health insurance. But now it would be hard to take away coverage.

General Motors Corporation with 211,000 Michigan workers covered:

The cutback in employe protection from M-75 to M-65 with no more justification than has been demonstrated thus far, would be difficult to accept. An estimated 10% of the GM workers would be affected if the top ceiling for service benefits dropped from $7500 to $6500. It looks like the doctors are willing to take a lower fee under M-65 in nine out of ten cases in order to have the right to charge a higher fee to one out of every ten. Very likely there would be complaints

Unit Values for M-75

	(to $2,500)	($2,500-$5,000)	($5,000-$7,500)
Surgery & Anesthesia	$3.00 up 21% over old $2,500	$3.75 up 12.5% over old $5,000	$4.50 up 35% over old $5,000
Medicine	4.00 up 15% over old $2,500	5.00 up 11.7% over old $5,000	6.00 up 34% over old $5,000
X-Ray	5.00*	5.00*	5.00*
Pathology	5.00**	5.00**	5.00**

*an increase of 24% for X-Ray over old $2,500 and $5,000.

**not increased, because Pathology is used for first time in M-75 contracts.

Unit Values for $6,500 Family-Income Contract

Surgery & Anesthesia	$2.60 (15% cut)	$3.25 (15% cut)	$3.65 (19% cut)
Medicine	3.45 (15% cut)	4.35 (15% cut)	4.85 (19% cut)
X-Ray	4.35 (15% cut)	4.35 (15% cut)	4.35 (15% cut)
Pathology	4.35 (15% cut)	4.35 (15% cut)	4.35 (15% cut)

(These are unit values approximately 15-19% below M-75)

from employes under M-65 about added-on charges by the doctors. It is likely, there would be fewer doctors participating. MMS, which is the doctor's plan should not offer a multiplicity of riders. The doctors are really the only ones competent to advise MMS and the public about which specific medical service should have priority for inclusion in the Blue Shield package. The employes are apt to suffer from lack of essential protection through poor choice of riders, if they must make the decisions.

UAW-CIO:

Unions have been skeptical about MMS and they took a big risk in endorsing M-75, but M-75 was progress. The M-75 plan is now "standard" for all UAW-CIO contract negotiations across the nation. Riders show a fundamental weakness. Why can't doctors decide on basic necessary protection, rather than offer all these riders? One of the best features about M-75 is the income certified arrangement. The trend is toward greater service and no income ceilings. Union people want comprehensive coverage. Ultimately we must move toward broader coverage. Unions will vigorously oppose any change—a situation with only M-65 would be intolerable.

The committee would like to point out that almost half of the people of Michigan look to Blue Shield for their medical security. In this way Blue Shield has become a public trust. The conversion to M-75 has only been completed this year, and this forced conversion from the old $2500 and $5000 contracts was bitterly resented by some subscribers. Now to again arbitrarily change the program could cause a public reaction that could be fatal to Blue Shield and to the private practice of medicine as we know it.

B. The Effect upon the Employer:

Next, let us deal briefly with the employer, who directly or indirectly foots the bill so his workers can have Blue Shield protection. We asked many questions during our conferences to learn what the reaction of the employers would be to a new $6500 contract.

General Motors now pays $39 million a year to provide hospital-medical coverage for its workers. This figure grows to $78 million when you include the half paid by the workers. When GM took on M-75, in 1958, the costs in Michigan of medical care coverage for their workers went up 48%, and now with the new MMS rate increase, the costs will be 65% higher than in 1958. General Motors has accepted these higher costs in the interest of making available the broader protection that employes need. Besides these direct costs, GM has been willing to absorb the added expense of certifying annually to Blue Shield the income classifications of its 211,000 enrolled employes. General Motors indicated that the 1961 labor agreement must make specific provisions no less favorable than M-75 which is standard in the 1958 GM agreements.

Ford pointed out that Michigan is a key state in the Ford operation and the company would be committed to offer any substitute plan nearest M-75 if M-75 were not available. Ford reports that about 20% of its workers would not be covered now by a $6500 ceiling and within three years, two-thirds would not be covered if the present rate of wage increases continue. This would make a $6500 service ceiling almost impossible for Ford to adopt. [I hope you all got that one.]

The city of Detroit reported that a proposal of the John Marshall Company is being investigated because that firm claims it can provide the same services as Blue Shield at a better price.

The Detroit Board of Education reported that 5600 school employes are enrolled with Provident for their health protection. About the same number 5500 are covered by Blue Shield. The school representative pointed out that "I suspect there would be many complaints if MMS changed from $7500 to $6500." He added, "Whereas Blue Shield has promised and has delivered service now up to $7500, it would under the change provide service only up to $6500, while those covered by Provident insurance would continue to get the same amount of money as they always have." Beginning this fall, the Detroit Public School System will pay 100% of the cost for employes for Blue Shield whereas in the past they have paid 50%.

C. Effect upon the Doctors of Michigan:

Now let us consider the effect change from M-75 to M-65 would have upon the members of the Michigan State Medical Society who have been supplying the services for the Blue Shield contracts. The M-75 contracts have been in effect for two years. A new high level of fees for all medical service has been established by this contract in the State of Michigan. It is difficult to imagine any voluntary retreat by the medical profession from the present level of fees that has been accepted by the consumers.

To arrive at the fee schedule for the $6500 family income contract, the unit values of M-75 are reduced as shown in the accompanying chart. Blue Shield fees are determined by multiplying these unit values by the relative values assigned the different procedures. Michigan is now using a modification of the California Relative Value Scale. It should be pointed out that the Michigan State Medical Society is now in the process of developing our own relative value scale.

The reactions of professional groups within the Michigan State Medical Society were heard at a special meeting of the Medical Care Insurance Committee September 10, 1960. Members of the Relative Value Study Committee also were present. Expressing their views were:

Michigan Pathological Society
Detroit Roentgen Ray and Radium Society—which represents the Roentgenologists in Michigan.
Michigan Society of Internal Medicine
Michigan Society of Anesthesiologists
American College of Surgeons, Michigan Chapter

Following are short summaries of the comments made by the spokesmen from these organizations: Most of their spokesmen were their presidents.

Michigan Pathological Society: Opposed to any reduction in unit values because pathology fees generally have not been raised since 1953. Traditionally, pathology has never had a sliding scale of fees according to different income scales and has no chance to pick up any lost income. There should not be a reduction in unit values for any medical service. M-75 fee schedule is adequate and M-75 has proven to be satisfactory.

Detroit Roentgen Ray and Radium Society: Any cut in unit values and fees under M-65 would result in a drastic loss for radiologists because they have one fee for all income groups and any loss would not be recoverable. The M-75 fee schedule is satisfactory now. Let's keep M-75 and correct any inequalities.

Michigan Society of Internal Medicine: Internal medicine is in a peculiar position—M-75 is not acceptable because the fee schedule does not recognize the degree of difficulty in the care of complicated cases, and if the same schedule is proposed for M-65, the Society will oppose it in principle. The Society supports the views of the Pathologists and Radiologists.

Michigan Society of Anesthesiologists: It is bad enough to have to work for M-75 fees. It would be ridiculous to take the 1950 $5000 contract fees which are proposed under M-65. We would be in a much better position to work to correct M-75 inequalities rather than go to M-65 and then try to correct them. Anesthesiologists will not stand by the M-65 fees—less than 50% participate now—and M-65 would become an indemnity contract.

American College of Surgeons, Michigan Chapter: If you change to M-65 a large number of surgeons would not participate. In reality, it is almost impossible for surgeons to make up the reductions in fees resulting from the proposed reduction in unit values. It would not be fair to surgery or any other part of the profes-

sion to consider a drop in income when we are faced with inflation and increased costs. Do not feel M-65 should be adopted.

Further study of a proposed fee schedule for the $6500 contract, taking procedures which make up about 30% of the total Blue Shield business, produces these results:

Comparison of Surgical Allowances
M-65 vs. M-75 and old $5,000 and $2,500 Contracts

Surgical Procedure	Plan C M-75	Plan C M-65	$5,000 Contract	M-65 Plan C As % of M-75	M-65 Plan C As % of $5,000
Appendectomy	$157.50	$127.75	$125.00	81%	102%
Gallbladder removal	247.50	200.75	175.00	81	115
Hemorrhoidectomy,					
Internal	90.00	73.00	75.00	81	97
External	22.50	18.25	30.00	81	61
Herniotomy, single	135.00	109.50	100.00	81	110
Normal delivery	90.00	73.00	70.00	81	104
Tonsil and adenoid	67.50	54.75	42.50	81	129
Weighted average	$ 95.72	$ 77.64	$ 71.24	81%	109%

	Plan B M-75	Plan B M-65	$5,000 Contract	M-65 Plan B As % of M-75	M-65 Plan B As % of $5,000
Appendectomy	$131.25	$113.75	$125.00	87%	91%
Gallbladder removal	206.25	178.75	175.00	87	102
Hemorrhoidectomy,					
Internal	75.00	65.00	75.00	87	87
External	18.75	16.25	30.00	87	54
Herniotomy, single	112.50	97.50	100.00	87	98
Normal delivery	75.00	65.00	70.00	87	93
Tonsil and adenoid	56.25	48.75	42.50	87	115
Weighted average	$ 79.76	$ 69.13	$ 71.24	87%	97%

	Plan A M-75	Plan A M-65	$2,500 Contract	M-65 Plan A As % of M-75	M-65 Plan A As % of $2,500
Appendectomy	$105.00	$ 91.00	$100.00	87%	91%
Gallbladder removal	165.00	143.00	140.00	87	102
Hemorrhoidectomy,					
Internal	60.00	52.00	50.00	87	104
External	15.00	13.00	25.00	87	52
Herniotomy, single	90.00	78.00	75.00	87	104
Normal delivery	60.00	52.00	50.00	87	104
Tonsil and adenoid	45.00	39.00	30.00	87	130
Weighted average	$ 63.81	$ 55.30	$ 52.53	87%	105%

After study of the $6500 family income contract, and after consideration of the many reactions from within the Michigan State Medical Society as well as from without, the Medical Care Insurance Committee recommends:

1. The M-75 contract be continued in its present form, with changes to be made as necessary, first on the basis of actuarial studies and second on the development of the Michigan Relative Value Study.

2. That further study be made of a basic contract with a low income ceiling.

3. That Blue Shield subscribers be educated as to the high costs of utilization and how they are individually affected by these increased costs.

4. That meetings be continued with top level business and industrial leaders, and with top level consumer representatives to seek their views on Blue Shield benefits and to stay abreast of their attitudes towards organized medicine in Michigan.

Total "Family" Annual Income Certificate versus M-75 "Subscriber Only" Income Certificate

Code	SURGICAL PROCEDURES DESCRIPTION	Rel. Value	TOTAL "FAMILY" ANNUAL INCOME Less Than $2,500	$2,500 $4,999	$5,000 $6,500	M-75 "SUBSCRIBER ONLY" INCOME "A"	"B"	"C" & "D"
	UNIT VALUES USED		$2.60	$3.25	$3.65	$3.00	$3.75	$4.50
0171	Biopsy of skin or subcutaneous tissue	2.0	$ 5.20	$ 6.50	$ 7.30	$ 6.00	$ 7.50	$ 9.00
0457	Complete (simple) mastectomy, unilateral	30.0	78.00	97.50	109.50	90.00	112.50	135.00
0470	Radical masteotomy, including breast, pectoral muscles and axillary lymph nodes	60.0	156.00	195.00	219.00	180.00	225.00	270.00
0807	Distal end, Colles' (including ulnar styloid) simple, closed reduction	15.0	39.00	48.75	54.75	45.00	56.25	67.50
2563	Ligation and division and complete stripping of long and short saphenous veins, unilateral	35.0	91.00	113.75	127.75	105.00	131.25	157.50
2992	Tonsillectomy, with or without adenoidectomy	15.0	39.00	48.75	54.75	45.00	56.25	67.50
3115	Subtotal gastrectomy	70.0	182.00	227.50	255.50	210.00	262.50	315.00
3261	Appendectomy (independent procedure)	35.0	91.00	113.75	127.75	105.00	131.25	157.50
3380	Hemorrhoidectomy, internal plus external	25.0	65.00	81.25	91.25	75.00	93.75	112.50
3515	Cholecystectomy	55.0	143.00	178.75	200.75	165.00	206.25	247.50
3821	Nephrectomy, with or without ureterectomy	70.0	182.00	227.50	255.50	210.00	262.50	315.00
4646	Dilation and curettage of uterus (independent procedure)	10.0	26.00	32.50	36.50	30.00	37.50	45.00
5021	Laminectomy	80.0	208.00	260.00	292.00	240.00	300.00	360.00
5611	Extraction of lens, intracapsular or extracapsular, unilateral	70.0	182.00	227.50	255.50	210.00	262.50	315.00
4801	Cesarean Section, classic	50.0	130.00	162.50	182.50	150.00	187.50	225.00
4802	Low cervical (lower urine segment)	50.0	150.00	162.50	182.50	150.00	187.50	225.00
4821	Obstetrical procedures: Obstetrical delivery	20.0	52.00	65.00	73.00	60.00	75.00	90.00

MEDICAL CARE

DURATION	TOTAL "FAMILY" ANNUAL INCOME Less Than $2,500	$2,500 $4,999	$5,000 $6,500	M-75 "SUBSCRIBER ONLY" INCOME "A"	"B" "C" & "D"
UNIT VALUES USED	$3.45	$4.35	$4.85	$4.00	$5.00 $6.00
1 Day	$ 8.63	$ 10.88	$ 12.13	$ 10.00	$ 12.50 $ 15.00
5 Days	22.43	28.28	31.53	26.00	32.50 39.00
10 Days	39.68	50.03	58.78	46.00	57.50 69.00
20 Days	74.18	93.53	104.28	86.00	107.50 129.00
30 Days	101.78	128.33	143.08	118.00	147.50 177.00

Hospital Days	Relative Value
1st day	2.5
2nd through 20th day	1.0
21st through 120th day	.8

Procedure Code	DESCRIPTION	Relative Value	TOTAL "FAMILY" ANNUAL INCOME BENEFITS IDENTICAL ALL CONTRACTS	M-75 "SUBSCRIBER ONLY" INCOME BENEFITS IDENTICAL ALL CONTRACTS
RADIOLOGICAL DIAGNOSTIC SERVICES				
	UNIT VALUES USED		$4.35	$5.00
7101	Chest with multiple views	3.0	$13.05	$15.00
7210	Spine, lumbosacral	3.5	15.23	17.50
7358	Upper gastro-intestinal series	5.0	21.75	25.00
7364	Cholecystography	4.0	17.40	20.00

RADIOLOGICAL THERAPEUTIC SERVICES

	PROVEN MALIGNANCY OR TUMORS Super Voltage Fees are 125% of Deep		DEEP	SUPER VOLTAGE	DEEP	SUPER VOLTAGE
7573	Cervix, radium insertion	25.0	$108.75	$135.94	$125.00	
7592	Postoperative	35.0	152.25	190.31	175.00	$218.75
7612	Hodgkins, maximum per annum	80.0	348.00	435.00	400.00	500.00
	minimum per treatment	2.0	8.70	10.88	10.00	12.50

PATHOLOGICAL EXAMINATIONS

Procedure Code	DESCRIPTION	Relative Value	TOTAL "FAMILY" ANNUAL INCOME BENEFITS IDENTICAL ALL CONTRACTS	M-75 "SUBSCRIBER ONLY" INCOME BENEFITS IDENTICAL ALL CONTRACTS
	UNIT VALUES USED		$4.35	$5.00
8620	Blood, red cell count	0.4	$ 1.74	$ 2.00
3681	Hematocrit	0.5	2.18	2.50
8726	Sugar	0.8	3.48	4.00
8950	Electroencephalogram	5.0	21.75	25.00
8957	Electrocardiogram, with interpretation and report	3.0	13.05	15.00

CONSULTATION SERVICES

Procedure Code	DESCRIPTION	Relative Value	TOTAL "FAMILY" ANNUAL INCOME Less Than $2,500	$2,500 $4,999	$5,000 $6,500	M-75 "SUBSCRIBER ONLY" INCOME "A"	"B"	"C" & "D"
	UNIT VALUES USED		$3.45	$4.35	$4.85	$4.00	$5.00	$6.00
026	Consultation for a given system not requiring complete examination—in patient	2.0	$ 6.90	$ 8.70	$ 9.70	$ 8.00	$10.00	$12.00
027	Consultation requiring complete examination—in patient	4.2	14.49	18.27	20.37	16.80	21.00	25.20
	TECHNICAL SURGICAL ASSISTANTS							
	UNIT VALUES USED		$2.60	$3.25	$3.65	$3.00	$3.75	$4.50
194	A fee for assistant, when eligible, to be placed at level of 15% of surgical fee, subject however, to minimum payments as follows:	6.0	$15.60	$19.50	$21.90	$18.00	$22.50	$27.00

ANNUAL REPORTS OF THE COUNCIL (Continued)

33. Supplemental Annual Report of Committee on Study of Insurance Problems for MSMS Members

On August 17 the committee met to consider four questions raised by MSMS members regarding the MSMS Group Life and Health and Accident program. These matters were resolved and answers directed to the correspondents.

Also the committee prepared a reply to the American Medical Association at the request of The Council, to the effect that the committee believes that the study and/or development of group annuity and disability insurance programs are a proper area of activity of the AMA, although MSMS would prefer to reserve the right to inaugurate a state program, if this should prove desirable, and not commit itself to any national plan that may be offered by the American Medical Association.

After reviewing expert opinion as to the feasibility and desirability of offering a major medical coverage to MSMS members, the committee approved in principle this idea and agreed to begin study of various plans for recommendation to The Council. At future meetings specific plan outlines will be reviewed.

34. Committee on Awards

The Awards Committee took action toward the establishment of the Gold Medal Award, determined that Dr. Wilfrid Haughey's long and valuable service to MSMS and its Journal be recognized by dedication to him an early number of the Journal, MSMS, and approved in principle a system of awards to the employes—a recommendation on this subject follows.

At the MSMS Awards Banquet on January 30, 1960, in Detroit, the following national medical leaders from Michigan who have performed outstanding service to their profession were honored: Reed M. Nesbit, M.D., Ann Arbor, President of American Association of Genito-Urinary Surgeons; H. Marvin Pollard, M.D., Ann Arbor, President of American Gastroenterological Association; Milton L. Sorock, M.D., President of the Johnston Surgical Society; Archer A. Claytor, M.D., Saginaw, chosen Michigan Foremost Family Physician of 1959 by the House of Delegates and nominated by MSMS for the American Medical Association's 1959 General Practitioner Award.

In addition, the following individuals were cited for various contributions to health and medicine, or the public understanding thereof: Miss Ella K. Longley, Ludington; Muskegon *Chronicle,* Muskegon; Mr. C. S. Mott for his many contributions, Flint; and the following radio stations: WAGN, Menominee; WBCK, Battle Creek; WBRN, Big Rapids; WDET. Detroit; WELL, Battle Creek; WLDM, Detroit; WMDN, Midland; WOAP, Owosso, and WWBC, Bay City.

35. MSMS Representatives to Michigan Cancer Coordinating Committee

During the past Society year—from September 30, 1959, to September 24, 1960—the Michigan Cancer Coordinating Committee held three meetings; on February 4, June 30, and September 8, 1960.

1. The chief organizational change during the year was the acceptance on June 30 of the reconstituted Southeastern Michigan Division of the American Cancer Society and of the Michigan Cancer Foundation as new organization members of the Michigan Cancer Coordinating Committee.

Representation of several organization members also were amended as follows:

The membership of the Michigan Division of the American Cancer Society was raised from three to four persons—including two professional and two laymen—the Southeastern Michigan Division of the American Cancer Society was given two members—one professional and one layman—the Michigan Cancer Foundation also was given two representatives—one professional and one layman.

All the other organizations' members continue with the same representation as in the past, i.e., four members plus one alternate for the Michigan State Medical Society; one each for the Michigan Department of Health, the Michigan Health Officers Association, and the Michigan State Dental Association.

2. Progress of the Central State-wide Cancer Registry was slowed pending the above changes and the holding of a meeting on September 8 of representatives of the seven organization members with board members of the Michigan Cancer Registry.

Revisions of the bylaws of the Michigan Cancer Registry are being studied prior to final decision on the creation of a Central Cancer Registry; members of the Michigan Cancer Coordinating Committee favor Wayne State University College of Medicine for the site of the registry.

3. The work of the Cancer Quackery Subcommittee under the able chairmanship of B. E. Luck, D.D.S., has been vigorous, imaginative, and productive. Photographs of the Cancer Quackery Exhibit have been sent to all its divisions by the American Cancer Society as part of its educational effort throughout the United States; the subcommittee's exhibit has had many showings in various parts of the state; its leaflet "Beware the Cancer Quack." has been widely disseminated; the present work of the committee is the drafting of a Michigan cancer quackery law—such as in California, Nevada and Kentucky.

4. The Michigan Cancer Coordinating Committee continues to sponsor:

a) the Michigan Cancer Coordinating Committee Lecture at the annual Michigan Clinical Institute
b) The cancer Number of JMSMS in April
c) to publish and distribute a goodly supply of literature including its own revised cancer manual, "Strength Through Unity Against Cancer," in addition to the AMA's excellent publication "The Four Horsemen of Cancer."

5. The MCCC approved the American Cancer Society's new film strip entitled "To Smoke or Not to Smoke" developed for showing primarily to teenage students. The Detroit Board of Education has purchased numerous copies to be shown in high schools.

6. Your MSMS representatives to the Michigan Cancer Coordinating Committee feel that the state society should fully cooperate in this seven-year-old activity—MCCC was created November 12, 1953—because of several distinct advantages:

a) Better communication between the seven organization members results in mutual knowledge of the projects of each other.
b) The generating of friendship among the representatives of these seven organizations primarily interested in cancer control leads to understanding and confidence in one another and the over-all program.
c) Financial savings come from elimination of overlapping and duplication in cancer control work in Michigan.

Informing Our Members

Dr. Meier: Between sessions of the House of Delegates, all business of the Society funnels through The Council—according to the bylaws—which meets monthly. The Council minutes now have reached over twenty pages per month and copies of full deliberations of The Council are transmitted monthly to secretaries of the component county societies, and to all seated delegates —who request them. These are the identical official minutes as received by the individual members of The Council, not digests. It has been suggested that more detailed information regarding Council actions would be desirable. The Council had deliberated on this request of a few members and feels that verbatim reports of The Council's discussions do not seem feasible; even

the most detailed minutes would require amplification by a member of The Council if a particular question was asked by a delegate or a county society officer. Certainly, all the Councilors are more than willing to answer any and all questions and provide any information upon request. In its attempts to communicate its deliberations fully to the membership, it has forwarded its identical official and complete minutes, monthly as indicated above. If, however, the membership desires further information, The Council cordially invites a representative of any component society to be a guest observer at any Council meeting.

Campaign for Freedom

President Darling has said, "Adequate funds are needed to meet emergencies such as the recent 'crash program'—Campaign for Freedom—to aid in defeating Forand-type legislation, which proved most effective. The avalanche of protests from the grass roots directed to the Halls of Congress had a most salutary effect in stiffening resistance to pending medical legislation tied to Social Security. Both political parties have indicated they will press for additional legislation in the coming session; consequently we should be prepared financially to marshal our forces with renewed vigor."

Little need be added to these comments other than to emphasize the long-term aspects which are mandatory in the Campaign for Freedom as a deterrent force to inimical legislation coupled with the President's Program as a positive progressive project of MSMS to meet the needs which exist in the medical and health fields.

Recommendations

We respectfully invite your attention to the nine recommendations in the original Annual Report of The Council, printed in the Handbook, beginning on Page 82. They read as follows:

1. That the House of Delegates give approval to the Presidents Program and urge enthusiastic support of this important project by all members.
2. That The Council be authorized to arrange Councilor Conferences, prior to the Annual Session, to continue communication and share information with delegates, alternate delegates and component society officers, as during the past three years.
3. That the House of Delegates give fitting recognition to the first Michigan lady to become President of the Woman's Auxiliary to the American Medical Association—Mrs. W. G. Mackersie.
4. That the House of Delegates approve the holding of an annual "General Meeting" of the State Society.
5. That component societies be encouraged to sponsor "County-State Society Nights" once per annum, to augment communication and information on matters vital to the full memberships of all county societies in Michigan.
6. That the House of Delegates approve amendment to the bylaws—Chapter 10, Section 1—to confirm the traditional practice of electing the officers of The Council in September, immediately after the election of new councilors by the House of Delegates.
7. That the House of Delegates reactivate the MSMS Cancer Control Committee by approving amendment to bylaws—Chapter 11, Section 3—as the guidance and advice of this committee is necessary at this time.
8. That The Council be authorized to send MSMS representatives to Washington, D. C., in 1961 on the occasion of the Annual Michigan Day as recommended for many years by the House of Delegates.
9. That the House of Delegates endorse the action of The Council in developing and implementing an intensified crash program against political medicine for the aged; further that the House of Delegates urge every MSMS member to recognize the seriousness of this threat and personally to inform his patients and other friends now of the fallacies and dangers of this ill-advised program which will dilute the present high quality of medical care for all people.

The Council respectfully submits the following additional recommendation:

10. That the House of Delegates favorably consider a resolution establishing a system of awards for the employed personnel of the Michigan State Medical Society based upon the length of time in satisfactory service and providing proper recognition in the form of insignia and other emoluments.

Lastly, to implement the obvious necessity to carry on our program and philosophy for the care of the aged and to make a dissent against the Michigan White House Conference on Aging.

Summarization of Proceedings of the Michigan White House Conference

By Public Relations Counsel Hugh W. Brenneman

Mr. Hugh Brenneman: Speaking as a public relations man, and from a technical standpoint and not a policy standpoint, I should like at this time to pay tribute to the UAW-CIO for its aggressive and systematic action to establish the welfare state in these United States. In this it has been particularly active in Michigan.

One of their objectives in this process is the passage of Forand-type legislation. The passage of this legislation is but one step in using the Social Security system to tax more, to gain more services from Government, and to give Government more control.

They failed in the last session of Congress to put through the Forand Bill, thanks to aggressive action by the doctors of medicine of this country. They failed in the Michigan Legislature in many other respects also, but their techniques are good. They are improving each year, and their successes are improving. There is no question about the fact they are going to continue to carry out the necessary activities to reach their objectives.

One of their techniques is to infiltrate conferences, recognized as being in the public interest, and using these conferences as tools of political pressure. One of these conferences which they did so use was the Michigan Conference on the Aging.

Let me give you an example of how it works. First, from the top down. If you will notice the Conference on Aging had as its speakers Governor Williams, Senator McNamara, Dr. Wilma Donahue. These three people, each of them, have expressed in the past their support of Forand-type legislation. In this conference the key section, the largest attended section and the section which meant most in regard to this policy was the Section No. 1, and their main program was on income maintenance. The chairman of this section was Wilbur J. Cohen. You will recall Wilbur J. Cohen was the compatriot of Mr. Michael Davis and Mr. Altmeier. The three of them were the chief protagonists for the Wagner-Murray-Dingle Bill of yesteryear. That's from the top down.

If you will notice, Victor Knox, who was on the House of Representatives Ways and Means Committee and helped to develop the Mills Bill. was not on the program.

You will notice that Charles Chamberlain, Representative from Lansing to Congress, and it was his home district, who was opposed to the Forand Bill, was not on the program in spite of the courtesy that is normally given to Congressmen when such a meeting is held in that area.

Now from the bottom up. I have no great knowledge about the other sections that were carried out in this conference. I think that there are men in this House of Delegates who can give you information in regard to those. I do have information about Section 1, chairmanned by Mr. Cohen because I had the privilege of serving as a resource person in this particular section. I was asked to be a resource person, and I accepted that assignment. I didn't know how many there would be.

When I got there I found out there were eighteen resource people in this particular section. Well, these were pretty qualified men I thought. I was very proud to be chosen to be one of these eighteen men.

Ladies and gentlemen, not one question during the entire section meeting was directed to a resource person. The resource person in this particular section was its chairman, Mr. Wilbur J. Cohen.

Now let us take this conference just a minute and see how it started. There were supposed to be regional conferences and then from these regional conferences there was supposed to be a state conference, and then from the state conference there was supposed to be and will be a White House Conference in Washington. In other words, it is a filter-up job, so that if you could get the thinking of the people and the facts on a regional level, and then filter those facts and bring them together on the state level, and then from the state level to the Federal level, you could get some real value out of this. This was the basis upon which the White House Conference has been established, and it is using money, as you know, appropriated by the Federal Government in order to accomplish this.

Well, at the regional conferences it is interesting, the fact sheet there that was distributed for use by the regional conferences was prepared by Mr. O'Dell of the UAW-CIO.

I think that there are people here who could testify also that the regional conferences' reports in some instances anyway, were written prior to the time that the regional conference was held. However, nonetheless, at this particular section meeting that I attended, there were a number of resolutions given to us, that is, a number of items. These items were prepared, and they were the things we were going to talk about with such additional things as might come up, introduced by those persons in attendance. So the question was asked, and it was asked by Mr. Dougherty, the Executive Secretary of the Michigan Health Council: "Where did these resolutions come from?" The answer was given that they came from the regional conferences. It was then pointed out that one of the recommendations was, and I read, as follows:

"In the meantime speedy action should be taken by the State Legislature so that Michigan's indigent aged can qualify for the limited medical care provisions of the 1960 amendments to the Social Security Act, the Mills Bill."

This was passed by Congress and signed by the President after the regional conferences were all held. How could this have come up from the regional conferences? So then, when this was pointed out, Mr. Cohen said, and I quote him directly: "What was done and decided at the regional meetings has no particular bearing on this meeting. We are here to discuss these topics ourselves." So it was wide open.

Who was present in this room? Meeting for lunch there was a group of about ten men. These ten men were paid employes of the UAW-CIO. These men came into the meeting and seated themselves in various portions of the room, and whenever one of these subjects came up, one of these men, another, another, another would get up and speak upon this subject, and not bringing facts to bear, but trying to raise the emotions of those present. Who were present? The members, the great majority, were the golden agers, as you know, from the UAW-CIO. Consequently, you have quite an unusual situation with a chairman who was the authority, the resource persons who were not asked to speak, and the main comment coming from paid employes of the UAW-CIO.

So there was a point in this where it became obvious there was no question about the fact they were going to pass every single liberalization of the Social Security Act that had been outlined for them in this list of things which were supposed to come from the regional conferences but did not come from the regional conferences, and so it was at that point, after talking with a couple of the doctors who were present, I said: "Gentlemen, it is very obvious that this section is dominated by comments from paid workers of the UAW-CIO. It's stacked. Those people who are present are along in years, and I suspect that if those who were here were younger, they might have a different way of voting on this, a different vote on it, because it is obvious that the people here are not going to pay for this. The people that are going to pay for it are the youth, the children and the grandchildren. This is the finest example of plain unadulterated selfishness it has ever been my opportunity to observe, and I herewith withdraw my name as a resource person. I am leaving," and I did.

I say to you, gentlemen and ladies, there is no question about the fact that this is typical of how the UAW-CIO intends to use those organizations and those situations which have the aura of respectability, for their own political purposes. There is no question about the fact that The Council has established the Campaign for Freedom, but that Campaign for Freedom, ladies and gentlemen, succeeded as it did only because of the activities of the individual doctors of medicine.

I can say to you that the UAW, the unions generally, have a campaign. They fear no organization. They fear only the aroused medical profession where the individual doctor of medicine feels so highly of his profession, so dedicated to his principles, that he is willing to fight for them.

I would like to pay tribute to Dr. H. B. Zemmer who is a member on the Michigan Commission on Aging, who is a member of this House of Delegates, and who has done a superb job in trying to hold the line on that Commission. I think his story best exemplifies the situation insofar as the Michigan Conference on Aging.

This is the story. It seems that Jake had been out playing poker one night, and he came home. His entire shirt and coat were just literally drenched with tobacco juice. Molly, his wife, said, "Jake, if you have to chew tobacco, can't you turn your head to spit?" And Jake said, "Molly, not with those boys I play with."

REPORTS OF THE COUNCIL (Continued)

H. J. Meier, M.D.: As I said lastly, these are the recommendations of The Council in view of these statements.

1. MSMS invite other participants in the Michigan White House Conference on Aging to join with it in issuing a dissenting report of the conference, which is to be transmitted to the national conference in Washington in January 1961.

2. MSMS express to the Michigan Legislature its concurrence in the two measures approved by that body on September 23, 1960 which provide health benefits for our needy aged citizens. MSMS also should extend to the Legislature and other state departments and agencies affected by this new legislation its fullest cooperation in implementing the new program and assessing the results.

3. MSMS develop and carry out an alive, alert and dynamic program of civic participation in all proper political and legislative spheres to insure continuation of the principles it believes to be in the best interests of the American public—as part of the Campaign for Freedom.

4. MSMS periodically consider allocation of sufficient funds and provision of adequate staff personnel as they become necessary for the successful pursuit of the above purposes.

Respectfully submitted,

The Council
H. J. Meier, M.D., *Chairman*
T. P. Wickliffe, M.D., *Vice Chairman*
A. E. Schiller, M.D.
O. B. McGillicuddy, M.D.
William A. Scott, M.D.
C. Allen Payne, M.D.
H. H. Hiscock, M.D.
C. N. Hoyt, M.D.
E. S. Oldham, M.D.
D. G. Pike, M.D.
O. J. Johnson, M.D.
W. M. LeFevre, M.D.
B. T. Montgomery, M.D.
B. M. Harris, M.D.

R. J. Mason, M.D.
G. Thomas McKean, M.D.
W. W. Babcock, M.D.
William Bromme, M.D.
J. J. Lightbody, M.D., *Speaker*
H. F. Falls, M.D., *Vice Speaker*
Milton A. Darling, M.D., *President*
K. H. Johnson, M.D., *President-elect*
D. Bruce Wiley, M.D., *Secretary*
W. A. Hyland, M.D., *Treasurer*
G. B. Saltonstall, M.D., *Past President*

The Speaker: The Annual and Supplemental Reports of The Council will be referred to the Reference Committee on Reports of The Council except that portion of the report having to do with the supplemental report of the Medical Care Insurance Committee which will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

VII. REPORT OF DELEGATES TO AMERICAN MEDICAL ASSOCIATION

By Wm. A. Hyland, M.D.

The AMA Annual Session Report is on pages 84 to 91 in your handbook. Therefore, with your permission, Mr. Speaker, I will bring you up to date on the present state of the American Medical Association and dispense with reading the report in the handbook. Thank you, sir.

Let's Keep the A.M.A. Healthy.

The life of the American Medical Association in many respects is similar to the life of an individual. An association is born, grows in strength, is beset by ills and unless properly cared for, may succumb to a fatal disease. Like an individual, an association in order to survive must be healthy; physically, intellectually, and spiritually. However, though human life, physically speaking, must have an end, an association kept strong, virile and healthy by the combined efforts of its membership can live forever.

The American Medical Association is 113 years old. It was founded in Philadelphia on May 5, 1847 by 250 physicians representing twenty-two states and the District of Columbia. They gave it sturdy tissues, strong muscles, and a sound heart. Today it ranks as one of the most powerful and constructive associations in the world, great in material possessions and rich in spiritual resources.

From a "handful of members" in 1847, the association has grown into a membership of 179,000 physicians; from an "out-of-pocket" budget in 1847, the association has built its present income to more than $15,000,000 annually; from a one-room beginning in the Academy of Natural Sciences in Philadelphia in 1847, the association today occupies a headquarters building with a replacement value of more than $8,000,000 and from a one-man operation in the person of Founder Nathan S. Davis, the association's work today is carried out by a staff of more than 700 skilled people.

All of these things denote a gradual and healthy growth.

The founding fathers, in laying the foundations of the American Medical Association planned well.

The preamble attached to the Constitution declared the purpose of the organization to be "for cultivating and advancing medical knowledge; for elevating the standard of medical education; for promoting the usefulness, honor and interests of the medical profession; for enlightening and directing public opinion in regard to the duties, responsibilities and requirements of medical men; for exciting and encouraging emulation and concert of action in the profession, and for facilitating and fostering friendly intercourse between those engaged in it."

These were lofty principles and they are as applicable today as they were in 1847. These principles born amid turmoil and conflict between physicians and medical schools that smacked of quack shops and diploma mills, were the beacon lights, the compasses of direction, that guided the paths of American physicians toward the magnificent achievements of the next century.

But today the association's responsibilities are growing at an ever-increasing rate. Idealogies and shady thinking, spawned in the sunshine of government bureaucracy for a long time, have infected the blood stream of the AMA. These germs are deadly, easily transmitted, and often difficult to detect.

The key to the future must be alertness, eternal vigilance, and the maintenance of calmness. A healthy AMA, like a healthy body, must receive the unstinting cooperation of all its component parts; if one part fails to carry its share the whole organism is weakened. The American Medical Association must remain strong and healthy. This is the responsibility of every physician.

The American Medical Association is your association and in these times of rapid scientific, social and economic change, it needs your unstinting support.

In capsule form, I would like to trace the growth of AMA activities—not for the purpose of attempting any detailed history, but to demonstrate the great number and variety of association services as they exist today for your benefit.

For each $25 in dues that came into the AMA treasury last year, $14.50 went for subscriptions to AMA publications—$7.50 for the Journal, $4 for a specialty journal, $1.50 for the *AMA News,* and $1.50 for *Today's Health.*

This left $10.50 from each $25 to help finance the many services—both professional and public—which AMA provides.

How was this $10.50 plus the revenue derived from advertising, sale of exhibit spaces at the annual and clinical meetings, and income from investments, spent to help you?

In addition to the AMA publications, which have become the main source of medical information for the profession as a whole, the association promotes the exchange of scientific information through exhibits at the annual and clinical meetings each year.

The first scientific exhibit—a pathology display—was presented at an AMA meeting in 1899. Today at a typical AMA annual meeting each June—you can see almost 700 scientific and technical exhibits which make up just one part of a huge, five-day, postgraduate session planned by the associations Council on Scientific Assembly. While the AMA grossed $414,000 last year from the sale of exhibit space at the annual and clinical meetings, the 1959 expenditure for the entire scientific division, with 119 staff members, totaled $1,070,000.

Physicians who attend AMA annual conventions spend many hours listening to scientific lectures. They view 325 scientific exhibits, talk to representatives of pharmaceutical houses, surgical supply houses, and others in 275 industrial exhibits, and watch continuous medical films and color television. Every presentation is geared to the interests of the modern physician and to the extension of modern medicine.

In 1904, with the establishment of the Council on Medical Education and Hospitals, the AMA began the ever-increasing activities which have given our country its present high standards of medical school and hospital training. This council, among other things, conducts an extensive medical school inspection and evaluation program; evaluates and lists approved programs of internship and residency training; publishes comprehensive lists of postgraduate education programs for physicians; evaluates training programs for technologists and allied medical personnel, and cooperates closely with the Educational Council for Foreign Medical Graduates. Right now a major task is to provide leadership and guidance for a sound expansion of our medical education system to meet the future needs of a rapidly growing population.

The American Medical Education Foundation was founded by the AMA in 1950 to help the hard-pressed medical schools financially without any string attached. Since then the AMA has contributed outright grants

totaling $2,525,000 and also paid out a total of $861,000 to cover all administrative expenses.

The year 1905 brought formation of the Council of Pharmacy and Chemistry, now called the Council on Drugs, which reports to the profession on the reliability, therapeutic value and limitations of pharmaceutical products.

As a sidelight in connection with this council's work, for years AMA was the only major organization working to insure drug safety and to stamp out quackery and misleading advertising. AMA efforts paved the way for passage of food, drug and cosmetic laws and for the establishment of the Federal Food and Drug Administration, which now oversees drug manufacture.

The following year came the Bureau of Investigation, which collects and distributes information on quack doctors, healing cults, patent medicines, and medical fads.

Although AMA itself does not prosecute the quacks who pass themselves off as medical men or the unscrupulous manufacturers of worthless potions or machines, by supplying information to organizations such as government agencies, Better Business Bureaus and civic groups, AMA has helped put many dangerous quacks and promoters out of business. Because these individuals say they can "cure" anything, they are as dangerous as the most wanted criminal—they keep people who can be helped by medical science away from doctors, sometimes until it is too late.

Health education for the public became an organized service of the association in 1911. Later, in response to a growing demand for sound information on medical subjects, AMA in 1923 began publication of a magazine for laymen. Originally, named *Hygeia*, it now is called *Today's Health*.

The Bureau of Legal Medicine and Legislation was established in 1922, and then in 1954 its work was absorbed by the newly-created Law Department, whose seventeen staff members work on a wide variety of medico-legal and legislative subjects—all of vital interest and concern to the medical profession.

This department, which had a total expenditure of $186,000 last year, provides legal service and advice to the Board of Trustees, House of Delegates, officers and executive staff of AMA, and to various divisions, councils, committees, and departments. The division conducts original research and publishes numerous medico-legal reports.

To study and evaluate devices used in medicine, the AMA in 1925 set up the Council on Physical Medicine and Rehabilitation, now known as the Council on Medical Physics. The increasing interest in nutrition and special food products led to creation of the Council on Foods and Nutrition in 1929. The Economic Research Department which makes a variety of studies on the costs and distribution of medical services, began its work in 1931.

Developments in protecting the health of workers brought about establishment in 1938 of the Council on Industrial Health, recently renamed the Council on Occupational Health. The Council on Medical Service, organized to study the effects of social and economic changes on medical practice, was created in 1943. Cooperating with farm groups, communities and the medical profession in focusing attention on rural health problems is the Council on Rural Health which began in 1945.

The next year, 1946, brought the Department of Medical Motion Pictures, whose activities now include television and are an important part of the programs at our annual and clinical meetings. In that same year the association established a Public Relations Department to keep both the profession and the public informed about American medicine's policies, viewpoints and services. With a program greatly expanded both in size and scope, it now is known as the Communications Division.

This division whose expenditures last year totaled $1,232,000 promotes all AMA activities, and utilizes every conceivable medium—radio, television, newspapers, and magazines, printed pamphlets and bulletins, posters, leaflets, exhibits, speakers, movie film strips and slides, books, meetings, and formal instruction in schools. The division is also responsible for the editing and distribution of the *AMA News* and *Today's Health*.

In 1947 the AMA created the Council on National Emergency Medical Service—now called the Council on National Security—which deals with matters in the fields of civil defense and military medical affairs. The rising number and variety of medical and health proposals in the United States Congress led in 1950 to formation of a Committee on Legislation. Now the Council on Legislative Activities works closely with the AMA Law Department and the AMA Washington office, which was established in 1944 as a listening post and two-way information center. The total expenditure of the AMA Washington office last year was $118,000.

As a result of the steady developments in psychiatry and the mounting national interest in the problems of mental illness, the association in 1952 set up the Council on Mental Health. Two years later the same council established a Committee on Alcoholism to concentrate on fact finding and program development in that particular field.

Still more recently, the AMA created a Committee on Aging to explore a wide range of subject matter related to the health and welfare of our older citizens.

And just recently the association established two new departments—preventive medicine and international health. It also made an initial grant of $100,000 to finance an exhaustive study by a new Commission on the Cost of Medical Care, which will delve into every phase of that subject.

These are just a few of the highlights of the many services available to you from your association.

On the scientific side, for example, some AMA staff people do the continuing, day-to-day work for Committees on Research, Rehabilitation, Toxicology, Pesticides and Cosmetics. Other staff personnel in the socio-economic area, are constantly gathering facts about such subjects as indigent care, maternal and child care, federal medical services, medical and related facilities, voluntary health insurance plans and medical care for industrial workers.

All of these activities and services, regardless of their nature, are carried out under directives and policies established by your House of Delegates. Association policy begins at the bottom—with the 179,000 physician members scattered throughout the cities, towns and hamlets of the country.

Their individual viewpoints—voiced and acted upon—determine the opinions of the 2000 county medical societies. Their county society delegates in turn decide the policies of the state medical societies. Then more than 200 delegates from state and territorial societies, the government services and the association's twenty-one scientific specialty sections—gathered together at the annual and clinical meetings of the AMA House of Delegates—determine the national policies. Between these two meetings a nine-member Board of Trustees, plus certain elected officers—all chosen by the House of Delegates—implement those policies.

As you can see from this broad outline, the American Medical Association as an organization is "big business" today. In fact, it has to be big to do the many things it is doing, both for the profession and for the public.

As the growth of AMA activities would indicate, we in American medicine are concerned with a wide variety of problems and challenges. They exist today and they will become increasingly important and burdensome to the entire profession in both the immediate and far distant future.

In addition to the many scientific challenges, stimulated by the rapidly changing dimensions of medical knowledge, we have others involving problems of education, organization of health services, socio-economic change and public relations. The American Medical Association is trying to approach them not merely as thorny,

complex problems, but rather as opportunities for American medicine to demonstrate its vitality and leadership. Let me try to interpret medicine's viewpoint toward some of the main challenges.

For example, in the field of medical education there is a vibrant spirit of change, experimentation and expansion. Working in a healthy climate of ferment and unrest, medical schools all over the United States are examining the quality and content of their educational programs. They are seeking the best possible ways of presenting a coordinated body of medical knowledge which will prepare the physician for practice in the changing scene of modern medicine. The AMA is encouraging and assisting all sound experimentation aimed at that goal.

In addition to the quality of medical education, we must face up to the challenge of quantity and the need for expansion in the years ahead. We cannot be complacent over past and present progress in keeping pace with our population growth. Looking at the future needs of a rapidly increasing population, we are trying to provide effective leadership in promoting the sound expansion of existing medical schools, and the creation of new medical education programs in the proper university settings. The AMA is intensifying its efforts to recruit qualified, dedicated young people into the study of medicine, and is now studying the possibility of sponsoring a scholarship program for medical students.

As we work to expand and improve undergraduate and graduate medical training, we also are extending our efforts to meet the challenge of postgraduate education. Recognizing that medicine actually is a lifelong study, we feel that all physicians and medical organizations have a responsibility to aid the development of sound programs for keeping the practicing doctor abreast of scientific advances. Our association is steadily expanding its program to provide the most up to date information and guidance in this field.

Related to the whole subject of medical education and training is the growth of specialization. Our challenge in the United States is to find ways and means of balancing and coordinating the work of general practitioners and specialists. We must make objective studies of the changing needs in all categories, and we must try to channel specialist services into over-all programs that are better tailored to meet the complete health needs of the people.

However, we feel that those needs never will be adequate through cold science and technology alone. We believe that we have the additional challenge—throughout the entire period of medical education, training and practice—of reemphasizing human values and restoring the warm, personal relationship so important to successful therapy.

Underlying everything ahead of us—in all countries, of course—is the future progress of medical research. This involves not only men, money and facilities, but also the task of promoting better coordination, eliminating duplication and bringing about economic utilization of our energies. A major challenge within this area is to stimulate both basic and clinical research leading to better knowledge of cardiovascular diseases, cancer, arthritis and all types of chronic illness.

This point is extremely important to all American physicians because it is closely related to the question of health care for the aged. This whole subject which has many facets, provides us not only with one of our major, long-range challenges, but also with the most serious legislative threat we have faced in ten years.

The American Medical Association has been leading a strong, vigorous and costly fight against this type of legislation for a long time. Speaking for American physicians, the AMA fears that this kind of legislation, no matter how limited to begin with, would be only the precedent—the opening wedge—for the development of national compulsory health insurance for our entire population. This would undermine and eventually destroy our whole system of voluntary health insurance, which has provided one of the most dramatic chapters in economic history.

These are just a few of the many problems and challenges that confront physicians and the AMA. Many of them already are being tackled with all the vigor the AMA can bring to them. But the AMA needs your wholehearted support. It speaks for American medicine and many times that voice speaks on your behalf. For in addition to serving physicians, the AMA works in the public interest. In a hundred ways, AMA crosses your life each day, even though you may not be aware of it.

So cherish your AMA membership as you do your citizenship, and get others to cherish theirs.

Membership in the American Medical Association is not a right, but a privilege, and with any privilege comes the responsibility to exercise it wisely and fruitfully. Reluctance to accept this obligation at a time when the world is encountering political, economic and military revolutions all at once could seriously damage our corporate strength. Perhaps this is why statesmen of the past have paid "duty" such a reverent service.

There is no privilege which is not inseparably bound to duty. Washington associated duty with conscience, which he called "that little spark of celestial fire." Rear Admiral George R. Clark thought it the most "sublime" word in the English language; to Robert E. Lee it was the "noblest." But it remained for a man whose way of life was far different from any American physician to state the proposition in its entirety.

To any who see conflict between right and duty, let him listen herewith to Mahatma Gandhi's words as he said:

"Duty is not the companion of rights, but the producer of rights. If we discharge our duties, our rights will not be far away; if we forsake our duty, then the rights we seek will never be ours."

Members of the House, on behalf of the Delegates and Alternates to the American Medical Association I wish to express our appreciation for allowing us to represent you as delegates and alternates. I wish to express my heartfelt thanks for your kindnesses and courtesies to me as your chairman.

THE SPEAKER: The regular report of the Delegates to the American Medical Association as printed in the handbook will be referred to the Reference Committee on Officers Reports.

VIII. REPORT OF WOMAN'S AUXILIARY TO MSMS

By Mrs. Harold H. Gay, President

Very early in June a detailed report of auxiliary activities was sent to Mr. Burns to be presented to The Council, so when he reminded me of this second report, I felt a good deal like the small boy who was confronted with an arithmetic exam in which he was required to make an equation for a problem that ran something like this: A field of 100 acres was plowed in two hours with a two-bottom plow. How long will it take to plow it with a three-bottom plow?

Now this was a little farm lad, and he knew the answer immediately, but he was not able to put it in the form of an equation. Not wishing to leave a blank space on his paper, he wrote: "Why the dickens do you want it plowed again, anyway?"

I am not sure you want the field plowed again either for my first report is in your little handbook which you may read at your leisure.

In lieu of the detailed report of the activities of the Woman's Auxiliary to the Michigan State Medical Society which has been given to The Council, I wish to report in brief its outstanding accomplishments for the year 1959-1960. There are also some additions since the June report which should be made.

But before listing our deeds of valor I want to express my own and the Auxiliary's appreciation and thanks to Mr. Burns, Mr. Tryloff, Mr. Roney and their stenographers and all others at the Lansing office for the very

considerate assistance, kind advice and invaluable service. Gratefulness can't be too often expressed and knowledge that there is a strong helping hand behind the scenes is a great comfort to a harried State Auxiliary President.

Not to be overlooked is the Society donation toward convention expenses. For this we wish to repeat our thank you. Though there were no questions of policy this year about which to consult our advisory committee, a letter was sent out by them to all county medical societies urging greater use of the county Auxiliary in the field of Public Relations and Education. This we greatly appreciate.

I am purposely omitting the range of my travels for the year, for it isn't where I went that is important, but the results of that travel apparent in Auxiliary accomplishment that counts. I can truthfully say that it has been a full-time job, and home and family have frequently been neglected as a result.

You are undoubtedly familiar with the Auxiliary program and its activities. I will touch briefly on the four priority projects.

Community service is, of course, the big field in which almost every doctor's wife, whether she is an auxiliary member or not, expends a great deal of her energies. It is in that area that her abilities as a public relations agent for you gentlemen and her husband in particular are tested and rated. In Michigan, activities which fall within the community service grouping cover almost anything one can name—from cub scout den mother through PTA to cancer drives, Red Cross service, a school for the deaf, to visits with the little old lady or gentleman around the corner, to getting out the vote. One cannot list all the community service projects in which doctors' wives engage. Who should know better what they are than you gentlemen yourselves?

Our Mental Health program is a rapidly growing one and shows every indication of becoming one of our major projects in the future while the Safety and Civil Defense programs continue to lag.

In cooperation with the Michigan Health Council, the Michigan League for Nursing and independently, the Auxiliary has continued its activity in the field of recruitment which is now being broadened to include all the paramedical careers as well as the profession of medicine. One county Auxiliary sponsors a future doctors' club. Auxiliaries during the past year have contributed $12,000 for loans and/or scholarships.

The AMEF program has been growing each year since it was begun. The total National Auxiliary contribution to AMEF for 1959 was $175,010. This was $35,000 more than has ever been given. Of this amount, Michigan contributed $7127.58—an increase over last year of $1593.35. But lest you relax in smug satisfaction with your Auxiliary's accomplishment, I would mention that Ohio topped all states with a $19,591 contribution; Texas $17,604.81 and Indiana and California each $13,000.00.

Our all-out efforts this year have been directed toward the legislative field. Education of the Auxiliary member concerning the evils of the Forand, Kennedy and similar health bills was undertaken at all district meetings on our trip through the upper Peninsula where each county auxiliary was visited, and through the March issue of the Auxilium. It was again stressed at the Midyear Board Meeting in March. At that time a resolution expressing disapproval of such legislation was sent to Congress where it became part of the congressional record. Many counties sent similar protesting resolutions and individuals wrote letters to their Congressmen and Senators. All Auxiliary members were urged to explain the evils of socialized medicine to lay friends and groups. At the same time some Auxiliaries developed constructive programs of problems of the aged which were sponsored by the Mental Health Committees.

Being asked to participate in the State Society's plan for fighting the Socialist inspired dream to provide free medical care for the aged is both flattering and invigorating. With the year's background work every Auxiliary member would be well prepared to follow the plan of action outlined by your state officers.

Since the recent congressional action temporarily stops further medical care legislation, Auxiliary members are directing their energies toward election activities. Direction for the next step must come from the medical society.

If you would have a greater and more effective response, let that direction come at the county level. Don't wait for your Auxiliary to ask you what you want done. The small, scattered and disinterested groups won't bother. To remain long without purpose threatens their existence. We were organized to give service, but it is hard to give service where none is required.

Kathleen Mackersie, the pride of our Auxiliary and the newly elected National President, said there was "great need for the doctor and the doctor's wife to work shoulder-to-shoulder with other citizens to meet the challenges posed by our increasing population of elderly Americans."

She also pointed out that with their knowledge and understanding of the services of medicine, "the Auxiliary walking side by side with the medical profession can help them preserve and enhance the heritage of American medicine." This I, too, believe.

At the state level this walking together is already accomplished. Now let us develop it at the county level.

THE SPEAKER: Mrs. Gay's report will be referred to the Reference Committee on Officers Reports.

IX. REPORT OF MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

By Mrs. Reta V. Stahl, President

This is indeed the high point of my year as president.

ACTIVITIES

In October 1959 the fourth annual convention of the American Association of Medical Assistants convening in Philadelphia was attended by four delegates and four alternates from Michigan. In addition, a large contingent of Michigan members also attended.

Dr. J. W. Rice was appointed chairman of the national advisory committee and Miss Hallie Cummins was elected to the office of national Treasurer. Six other Michigan members were appointed to service on various national committees.

Mr. Hugh Brenneman presented an interesting and informative lecture on "Leadership in Public Relations." At this annual meeting we witnessed the premier showing of the film "First Contact" produced by Wyeth Company for the American Association of Medical Assistants.

Next month Michigan will be represented by four delegates and two alternates at the annual convention of the American Association of Medical Assistants in Dallas, Texas. A bid for the national convention to be held in Detroit in 1962 will be made at that time. Michigan will present candidates for a national office and for the Board of Directors.

As in the past, two President's conferences were held. The November President's conference brought 76 officers and committee chairmen to Bay City to hear speakers from Dow Chemical Corporation. On May 1, 1960, a second President's conference was held in St. Joseph with 85 persons present. General theme of this meeting was Parliamentary Procedure.

On March 9, 1960, our third annual Educational Seminar was held in Detroit. In the past this seminar has been handled by the University of Michigan in cooperation with our Society, however, this year the seminar was planned and directed by our own members. Registration of 163 was slightly below that of the previous year, but response to the entire program was enthusiastic. We were honored to have Mr. Hugh Brenneman present the first annual L. Fernald Foster Memorial Lecture. We wish to thank The Council of the Michigan

State Medical Society for the use of their addressograph facilities which were a tremendous aid in handling our brochures for this seminar.

In October 1959, an Upper Peninsular Seminar patterned after our annual Educational Seminar was held in Ishpeming.

Representatives of our Society participated in discussions on health careers in three of the four regional conferences sponsored by the Michigan Health Council.

Upon request of The Council of the Michigan State Medical Society, our local societies assisted in the "Campaign for Freedom."

Our component societies have continued to be active in civic affairs. They have assisted the Woman's Auxiliary in projects in various areas as well as making their own contributions in numerous fields. Several county societies have developed scholarship funds, some on an outright grant to the receiver and some on a loan basis. These scholarships vary from premedical training to any health career training.

BULLETIN

Our Bulletin has continued to be published quarterly. As in the past, manuscripts and lectures from our various functions have been published. Michigan is especially proud of our first-place award in the national bulletin contest last year. This award was based on scientific content and journalistic ability.

ORGANIZATION

This year is the eleventh year of organization for the Michigan State Medical Assistants Society. We now have 25 component societies. Newly organized Macomb County, Marquette-Alger and Grand Traverse-Leelanau-Benzie area, known as Tri-County, will receive charters at this annual meeting.

Our membership totals 947 of which 293 are new members this year.

A membership trophy presented by our Advisory Committee will be awarded for the first time this year to the county with the biggest membership increase percentagewise during the past year.

EDUCATION

The Jackson and Lansing areas are now in the final semester of our In-Service Training Pilot Study. Courses are being taught in four other pilot study areas. The published course outlines are now available for use in other centers in Michigan.

We are experiencing some difficulty in several pilot study areas in meeting our necessary quota of students per class. Assistance of local medical societies in these areas is being urgently sought.

At the annual convention of the American Association of Medical Assistants in Philadelphia last year, Dr. Ralph Steffek of the Extension Department of the University of Michigan, presented the entire in-service program outline to the House of Delegates. It is our hope that this program will serve as the basis for a national educational program. The presentation received enthusiastic response and the entire course is now being taught in several states.

MEDICAL ASSISTANT OF THE YEAR

This year for the first time, a Medical Assistant of the Year will be honored. She will be chosen on a merit system based on activities in her local society, congenialty, leadership ability, and ability to work with others. An award will be presented by the Medical-Dental-Hospital Bureau of America.

OUR THANKS AND AN INVITATION

It has been a pleasure to serve as President of the Michigan State Medical Assistants Society.

Our Society greatly appreciates the interest and cooperation of the Council of the Michigan State Medical Society, and we are most grateful to the county medical societies and advisory boards for their assistance.

I should like to take this opportunity on behalf of the Michigan State Medical Assistants Society to invite you to attend any or all of our functions at the Hotel Statler on Wednesday and Thursday of this week.

THE SPEAKER: Miss Stahl's report will be referred to the Reference Committee on Officers' Reports.

I would like to take this opportunity of thanking the Woman's Auxiliary and the Medical Assistants Society for the yeoman job they did in assisting in the Campaign for Freedom. Both organizations did a terrific amount of work, so please take back the thanks of the House of Delegates to both of your organizations.

[The House recessed at 11 o'clock.]

MONDAY MORNING SESSION

September 26, 1960

The House convened at 9:05 o'clock with J. J. Lightbody, M.D., Speaker of the House of Delegates, presiding.

X. REPORT ON MICHIGAN MEDICAL SERVICE

By G. Thomas McKean, M.D., President

Corrections in Michigan Medical Service Annual Report to Delegates in Handbook.

1. On page 150 of the handbook one pargraph was omitted in Item G. Between the last two paragraphs on that page, the following should be inserted:

"After discussion on multiple occasions, action was taken by the Board to embody the sense of the above resolution in the following motion which was seconded and passed on June 8, 1960:"

2. On page 154, a paragraph that appears after the end of the letter from Commissioner Blackford does not belong in that place. We ask the delegates to read the paragraph and place it in the Professional Relations Section of the report.

3. On page 147 of the Handbook for Delegates, attention is particularly called to the final paragraph. To bring the House up to date, the following additional material is presented:

Continued study of the place for a $6500 Family Income policy in the program of Michigan Medical Service resulted in a detailed statement from management of Blue Shield which is summarized as follows:

It has been possible to attain conversion of 97% of our subscribers to M-75 because the public wants more benefits, more security in health care, and because price is a secondary concern. The 3% of subscribers who do not now hold M-75 have remained on old contracts because labor-management agreements totally prevented conversion to the newer policy up to date. M-75 sold in spite of its price increase handicap because it gave back to a large share of the market the service concept, and it added currently popular and broadly requested benefits.

In early 1961 the predominant portion of the motor industry will negotiate contracts with labor representatives. Up to this point there has never been a cutback in the health care coverage resulting from such negotiations. In fact, as much as half of the group enrollment has added coverage above the basic Blue Cross-Blue Shield for salaried personnel to the extent of a $1.00 to $5.00 monthly increase in premium.

M-75 with new income ceilings, new benefits, and certification of income resulted in a renewed faith of a majority of buyers in the Blue Plans and in the medical profession. Their trust and expectations were fulfilled. Once again, the service concept became a reality, and the image of the doctor in the eyes of a growing number of the public was strengthened.

The total MMS enrollment is about 1,300,000 contracts. About 9% are Plan D with no service obligation by the participating physician; about 17% are unmarried and for these there is no secondary income

problem; about 23% have income, not certified, contracts in which service eligibility is dependent on the income of the "principal contributor." In this 49% of contracts, the use of family income would create essentially no change in the obligation of a participating physician to provide service benefits.

The influence of the incomes of other family members on the actual service benefit level is believed to be too small to counteract the fact that, though certified income is based on 2080 hours per year, annual hours worked and compensated are actually about 1700 to 1800 hours.

It is statistically true that 9.5% of earning families fall in the $6500 to $7500 range. Consequently, little change in total number of service beneficiaries would result from this change.

A mandatory cutback in the service income limits or in benefits at this point, or in the foreseeable future, would be calamitous to enrollment in Michigan Medical Service. Such actions would create only one impression in the public mind; that the medical profession is reneging on its commitment to the service concept and its obligation to the public. From extensive expressions of public opinion, neither prepayment plans nor the medical profession can afford any such loss of public trust. Other providers of health insurance coverage stand ready to gain enrollment from such a reduction as a $6500 family income policy would offer. Vacillation on the part of Blue Shield and the medical profession supports such competitors.

A major campaign was necessary to convert holders of old plan Blue Shield policies to M-75. Can you picture the consternation and confusion should now the enrollment representatives of Michigan Medical Service tell these recent buyers that they have now to accept a lower level of coverage with less assurance of service?

Simultaneously with the above report from management, the Board learned of the incongruities that would appear in the fee schedule for a new $6500 family income certificate. Facing the evaluation of the position of Blue Shield in the market place and the economic effect on doctors, the Board of Directors on September 12, 1960, passed the following motion:

"That the Board of Directors direct Michigan Medical Service to report to the House of Delegates in September, 1960, tentative unit values, tentative rate schedules and tentative fee schedules on the $6500 maximum total family income contract with the three levels of income as requested by the House of Delegates in 1959, together with drafts of tentative contracts developed by management with respect to which final action by the Board has not been taken."

The report presently being read has been distributed to each delegate. A tentative draft of the above-mentioned contract is available should it be desired by delegates. The tentative rates for which management might ask approval of the Commissioner of Insurance and tentative fee schedules constitute Exhibits 2 and 3. These fee schedules were prepared in conformity with unit values—Exhibit 4—acted upon by the M.C.I.C. and passed by The Council of MSMS.

The Board finds itself unable to discontinue the sale of M-75 at the present time or in the near future. Minor changes in contract benefits continue to be under consideration.

The Board asks your careful consideration of all of this material prior to your final action.

On pages 148 and 149 of the Handbook, action prior to July 1960 on the recommendation of the 1959 House of Delegates that Michigan Medical Service accept the National Account Agreement has been detailed. Negotiations have been continuing with the National Blue Shield toward a contract embodying traditional Michigan principles but meeting so far as possible the requirements of the National Account Agreement. It is possible that before the termination of this meeting of the House of Delegates such a contract can be culminated.

On page 150, Section F, efforts to conform with a resolution of the 1959 House of Delegates are described. The results of these efforts have been distributed in the form of a Blue Shield brochure entitled "Your Blue Cross-Blue Shield Dollar" (Exhibit 5). Such a brochure will be mailed to all receivers of any type of literature from the Detroit office. Every effort will be made to attain the widest possible distribution of this brochure.

On pages 151 and 152 of the Handbook, you will note comments regarding the Federal Employe Health Benefits Act of 1959—a program now in full operation.

During the meetings with many delegates in the past month, it has become apparent that additional information regarding finances beyond that presented on pages 155 and 156 is necessary to prepare the delegates for making decisions in this session of the House.

Projections of our fiscal status, based on studies made by management, are not optimistic, nor do they promise that our operation will be in the black until another rate increase can be obtained. It is likely that on December 31, 1960, the contingency reserve figure will show a deficit of approximately three million dollars.

Subscribers to prepaid plans of all kinds have been using medical services at an increasing rate. The tendency for financial losses in every type of insurance for health care—be it stock company, or mutual company, a doctor sponsored plan or even a closed panel—has been universal. Such losses have been generally counteracted by intermittent rate increases in part or in whole.

In the case of Michigan Medical Service, the Insurance Commissioner on three occasions, starting in 1957, has not seen fit to allow a rate increase which would permit accumulation of a contingency reserve. Actually the increases have not kept pace with the increasing demand for doctor's services. Many have asked: "In what areas has Michigan Medical Service lost money?"

1. Much of the deficit present on our books resulted from a continuing loss experience with the old $2500-$5000 contract.

2. Plan A, the $2500 level in M-75 was a disproportionate loser, compared with losses for higher income level contracts. The value of this coverage to the low income retiree is manifested by this loss.

3. In-hospital medical care and out-of-hospital surgery were types of service which were major losers. On a much smaller scale, X-ray and coverage of such procedures as electrocardiograms also lost money. However, gains made in consultant coverage, laboratory benefits and surgical assistants' fees more than balanced the X-ray-EKG losses. In this way the so-called Class II Benefits came out in the black.

Extensive work is under way at the present time to implement many of the suggestions made by the Insurance Commissioner and by the Medical Profession. Studies of possible exploitation of benefits, of fraud, and of excessive payments are being made.

The National Association of Blue Shield Plans now holds us in full approval, in recognition of the efforts being made by the plan toward correcting the deficit position. Recognition has been given that it is fundamentally the action of the Insurance Commissioner that has not allowed the accumulation of any surplus.

In closing, I express my sincere thanks to individual members of the MSMS, and to this House of Delegates for showing great interest and for their careful consideration of the problems of Blue Shield in the next two days.

September 25, 1960
Exhibit-2

TENTATIVE RATE CHART

	TOTAL "FAMILY" ANNUAL INCOME		
	Less Than $2,500	$2,500 $4,999	$5,000 $6,499
Individual	$1.97	$2.32	$2.53
Two Person	$4.75	$5.62	$6.16
Family	$5.64	$6.72	$7.41

Above rates are based on Unit Values shown in Exhibit-4

SURGICAL PROCEDURES

EXHIBIT-3
TENTATIVE FEE SCHEDULES COMPARISON
FAMILY VS. SUBSCRIBER ONLY INCOME

APRIL 1, 1960

Procedure Code	DESCRIPTION	Relative Value	TOTAL "FAMILY" ANNUAL INCOME Less Than $2,500	$2,500 $4,999	$5,000 $6,499	M-75 "SUBSCRIBER ONLY" INCOME "A"	"B"	"C" & "D"
	UNIT VALUES USED		$2.60	$3.25	$3.65	$3.00	$3.75	$4.50
0102	Drainage of furuncle	2.0	$ 5.20	$ 6.50	$ 7.30	$ 6.00	$ 7.50	$ 9.00
0103	Drainage of small subcutaneous abscess	2.0	5.20	6.50	7.30	6.00	7.50	9.00
0108	Drainage of carbuncle	4.0	10.40	13.00	14.60	12.00	15.00	18.00
0114	Drainage of large subcutaneous abscess (where not specified elsewhere)	4.0	10.40	13.00	14.60	12.00	15.00	18.00
0130	Incision and removal of foreign body	2.0	5.20	6.50	7.30	6.00	7.50	9.00
0171	Biopsy of skin or subcutaneous tissue	2.0	5.20	6.50	7.30	6.00	7.50	9.00
0178	Local excision of small benign neoplastic, cicatricial, inflammatory or congenital lesion, one	3.0	7.30	9.75	10.95	9.00	11.25	13.50
0180	more than one	4.0	10.40	13.00	14.60	12.00	15.00	18.00
0190	Wide excision of lesion, without graft of plastic closure	5.0	13.00	16.25	18.25	15.00	18.75	22.50
0230	Excision of nail, nail bed or nail fold, simple	3.0	7.80	9.75	10.95	9.00	11.25	13.50
0238	Excision of pilonidal cyst or sinus	20.0	52.00	65.00	73.00	60.00	75.00	90.00
0445	Excision of cyst, fibroadenoma or other benign tumor, aberrant breast tissue, duct lesion or nipple (including any other partial mastectomy), unilateral	15.0	39.00	48.75	54.75	45.00	56.25	67.50
0457	Complete (simple) mastectomy, unilateral	30.0	78.00	97.50	109.50	90.00	112.50	135.00
0470	Radical mastectomy, including breast, pectoral muscles and axillary lymph nodes	60.0	156.00	195.00	219.00	180.00	225.00	270.00
0501	Aspiration biopsy of bone marrow, including sternal puncture	3.0	7.80	9.75	10.95	9.00	11.25	13.50
0686	Nasal, simple, closed reduction	5.0	13.00	16.25	18.25	15.00	18.75	22.50

Procedure Code	DESCRIPTION	Relative Value	TOTAL "FAMILY" ANNUAL INCOME Less Than $2,500	$2,500 $4,999	$5,000 $6,499	M-75 "SUBSCRIBER ONLY" INCOME "A"	"B"	"C" & "D"
	UNIT VALUES USED		$2.60	$3.25	$3.65	$3.00	$3.75	$4.50
0740	Clavical, simple, closed reduction	10.0	$26.00	$32.50	$36.50	$30.00	$37.50	$45.00
0761	Ribs, one, simple, strapping	3.0	7.80	9.75	10.95	9.00	11.25	13.50
0778	Humerous, surgical neck, simple not requiring manipulation	15.0	39.00	48.75	54.75	45.00	56.25	67.50
0798	Head, simple, closed reduction	10.0	26.00	32.50	36.50	30.00	37.50	45.00
0807	Distal end, Colles' (including ulnar styloid) simple, closed reduction	15.0	39.00	48.75	54.75	45.00	56.25	67.50
0821	Radius and ulna, simple, closed reduction with displacement	22.5	58.50	73.13	82.13	67.50	84.38	101.25
0842	Metacarpal, one, simple, closed reduction	7.0	18.20	22.75	25.55	21.00	26.25	31.50
0852	Phalanx or phalanges, one finger or thumb, simple, closed reduction	5.0	13.00	16.25	18.25	15.00	18.75	22.50
0967	Metatarsal, one simple, closed reduction	7.0	18.20	22.75	25.55	21.00	26.25	31.50
0980	Phalanx or phalanges, one toe, simple, closed reduction	3.0	7.80	9.75	10.95	9.00	11.25	13.50
1046	Arthrocentesis: puncture for aspiration of joint, initial	5.0	13.00	16.25	18.25	15.00	18.75	22.50
1047	subsequent	1.5	3.90	4.88	5.48	4.50	5.63	6.75
1244	Club foot and application of cast, unilateral	3.0	7.80	9.75	10.95	9.00	11.25	13.50
1246	bilateral	5.0	13.00	16.25	18.25	15.00	18.75	22.50
1413	Puncture for aspiration of bursa, initial	3.0	7.80	9.75	10.95	9.00	11.25	13.50
1928	Septectomy: submucous resection	30.0	78.00	97.50	109.50	90.00	112.50	135.00
2006	Ethmoidectomy, intranasal, unilateral	20.0	52.00	65.00	73.00	60.00	75.00	90.00
2010	bilateral	30.0	78.00	97.50	109.50	90.00	112.50	135.00
2081	Laryngoscopy, operative, including removal of papilloma or other tumor	20.0	52.00	65.00	73.00	60.00	75.00	90.00

Procedure Code	DESCRIPTION	Relative Value	TOTAL "FAMILY" ANNUAL INCOME Less Than $2,500	$2,500 $4,999	$5,000 $6,499	M-75 "SUBSCRIBER ONLY" INCOME "A"	"B"	"C" & "D"
	UNIT VALUES USED		$2.60	$3.25	$3.65	$3.00	$3.75	$4.50
2111	Bronchoscopy, diagnostic	15.0	39.00	$ 48.75	$ 54.75	$ 45.00	$ 56.25	$ 67.50
2193	Total or subtotal lobectomy	100.0	260.00	325.00	365.00	300.00	375.00	450.00
2315	Valvulotomy or commissurotomy	100.0	260.00	325.00	365.00	300.00	375.00	450.00
2434	Ateriography (exclusive of x-ray allowance)	10.0	26.00	32.50	36.50	30.00	37.50	45.00
2446	Blood Transfusion, replacement type, Rh factor	25.0	65.00	81.25	91.25	75.00	93.75	112.50
2563	Ligation and division and complete stripping of long and short saphenous veins, unilateral	35.0	91.00	113.75	127.75	105.00	131.25	157.50
2564	bilateral	60.0	156.00	195.00	219.00	180.00	225.00	270.00
2601	Splenectomy	60.0	156.00	195.00	219.00	180.00	225.00	270.00
2641	Biopsy of lymph node	5.0	13.00	16.25	18.25	15.00	18.75	22.50
2644	Excision of lymph node for diagnosis	5.0	13.00	16.25	18.25	15.00	18.75	22.50
2652	Upper cervical (suprahyoid) unilateral	40.0	104.00	130.00	146.00	120.00	150.00	180.00
2658	Axilla, unilateral	40.0	104.00	130.00	146.00	120.00	150.00	180.00
2665	Cervical (block dissection)	60.0	156.00	195.00	219.00	180.00	225.00	270.00
2693	Excision of mediastinal tumor	80.0	208.00	260.00	292.00	240.00	300.00	360.00
2992	Tonsillectomy, with or without adenoidectomy	15.0	39.00	48.75	54.75	45.00	56.25	67.50
3115	Subtotal gastrectomy	70.0	182.00	227.50	255.50	210.00	262.50	315.00
3179	Colectomy: resection of large intestine, partial	80.0	208.00	260.00	292.00	240.00	300.00	360 00
3261	Appendectomy (independent procedure)	35.00	91.00	113.75	127.75	105.00	131.25	157.50
3356	Incision and drainage of ischiorectal abscess (independent procedure)	10.0	26.00	32.50	36.50	30.00	37.50	45.00
3380	Hemorrhoidectomy, internal plus external	25.0	65.00	81.25	91.25	75.00	93.75	112.50
3384	Fistulotomy or fistulectomy and hemorrhoidectomy, internal and external	30.0	78.00	97.50	109.50	90.00	112.50	135.00

Procedure Code	DESCRIPTION	Relative Value	TOTAL "FAMILY" ANNUAL INCOME Less Than $2,500	$2,500 $4,999	$5,000 $6,499	M-75 "SUBSCRIBER ONLY" INCOME "A"	"B"	"C" & "D"
	UNIT VALUES USED		$2.60	$3.25	$3.65	$3.00	$3.75	$4.50
3388	Fissurectomy and hemorrhoidectomy, internal and external	25.0	65.00	$ 81.25	$ 91.50	$ 75.00	$ 93.75	$112.50
3515	Cholecystectomy	55.0	143.00	178.75	200.75	165.00	206.25	247.50
3517	with open exploration of common duct	65.0	169.00	211.25	237.25	195.00	243.75	292.50
3571	Exploratory laparotomy: exploratory celiotomy	35.0	91.00	113.75	127.75	105.00	131.25	157.50
3631	Hernioplasty: inguinal, unilateral	30.0	78.00	97.50	109.50	90.00	112.50	135.00
3634	Hernioplasty: inguinal, with excision of hydrocele or varicocele	40.0	104.00	130.00	146.00	120.00	150.00	180.00
3638	Hernioplasty: inguinal, bilateral	40.0	104.00	130.00	146.00	120.00	150.00	180.00
3661	Hernioplasty: ventral, incisional (independent procedure)	40.0	104.00	130.00	146.00	120.00	150.00	180.00
3817	Pyelolithotomy	65.0	169.00	211.25	237.25	195.00	243.75	292.50
3821	Nephrectomy, with or without ureterectomy	70.0	182.00	227.50	255.50	210.00	262.50	315.00
3857	Ureterolithotomy	60.0	156.00	195.00	219.00	180.00	225.00	270.00
3924	Transurethral resection of bladder tumors	50.0	130.00	162.50	182.50	150.00	187.50	225.00
3931	Cystoscopy, diagnostic, initial	5.0	13.00	16.25	18.25	15.00	18.75	22.50
3935	Cystoscopy, with ureteral catheterization, initial	10.0	26.00	32.50	36.50	30.00	37.50	45.00
3937	Cystoscopy, with stone removal, ureteral dilation, initial	20.0	52.00	65.00	73.00	60.00	75.00	90.00
3941	Cystoscopy, with fulguration of bladder tumor, initial	25.0	65.00	81.25	91.25	75.00	93.75	112.50
3945	Cystoscopy, with retrograde pyelogram (x-ray charges not included)	10.0	26.00	32.50	36.50	30.00	37.50	45.00
4122	Circumcision, newborn to age 1 month	3.0	7.80	9.75	10.95	9.00	11.25	13.50

Procedure Code	DESCRIPTION	Relative Value	TOTAL "FAMILY" ANNUAL INCOME Less Than $2,500	$2,500 $4,999	$5,000 $6,499	M-75 "SUBSCRIBER ONLY" INCOME "A"	"B"	"C" & "D"
	UNIT VALUES USED		$2.60	$3.25	$3.65	$3.00	$3.75	$4.50
4123	Circumcision, under age of 12	5.0	13.00	$ 16.25	$ 18.25	$ 15.00	$ 18.75	$ 22.50
4125	Circumcision, age twelve or over	8.0	20.80	26.00	29.20	24.00	30.00	36.00
4144	Orchiectomy, simple, unilateral	20.0	52.00	65.00	73.00	60.00	75.00	90.00
4176	Epdidiymectomy, unilateral	30.0	78.00	97.50	109.50	90.00	112.50	135.00
4316	Prostatectomy, suprapubic, one or two stages	70.0	182.00	227.50	255.50	210.00	262.50	315.00
4321	Transurethral electroresection of prostate, including control of postoperative bleeding complete	70.0	182.00	227.50	255.50	210.00	262.50	315.00
4481	Colpoplasty, anterior vaginal wall; repair of cystocele (independent procedure)	30.0	78.00	97.50	109.50	90.00	112.50	135.00
4488	Colpoperineoplasty, anterior and posterior vaginal walls: repair of cystocele, rectocele, and perioneoplasty	40.0	104.00	130.00	146.00	120.00	150.00	180.00
4545	Salpingo-oophorectomy, complete or partial, (independent procedure), unilateral or bilateral	40.0	104.00	130.00	146.00	120.00	150.00	180.00
4581	Excision of ovarian cyst (independent procedure), unilateral or bilateral	40.0	104.00	130.00	146.00	120.00	150.00	180.00
4611	Biopsy of Cervix (independent procedure)	3.0	7.80	9.75	10.95	9.00	11.25	13.50
4617	Panhysterectomy: total hysterectomy corpus and cervix)	60.0	156.00	195.00	219.00	180.00	225.00	270.00
4631	Vaginal hysterectomy	60.0	156.00	195.00	219.00	180.00	225.00	270.00
4641	Local excision of lesion of cervix, cauterization	4.0	10.40	13.00	14.60	12.00	15.00	18.00
4642	Local excision of lesion of cervix, conization	8.0	20.80	26.00	29.20	24.00	30.00	36.00

Procedure Code	DESCRIPTION	Relative Value	TOTAL "FAMILY" ANNUAL INCOME Less Than $2,500	$2,500 $4,999	$5,000 $6,499	M-75 "SUBSCRIBER ONLY" INCOME "A"	"B"	"C" & "D"
	UNIT VALUES USED		$2.60	$3.25	$3.65	$3.00	$3.75	$4.50
4644	Local excision of lesion of cervix in conjunction with dilation and curettage	10.0	26.00	$ 32.50	$ 36.50	$ 30.00	$ 37.50	$ 45.00
4646	Dilation and curettage of uterus (independent procedure)	10.0	26.00	32.50	36.50	30.00	37.50	45.00
4681	Hysteropexy, with ventrosuspension: ventrofixation	40.0	104.00	130.00	146.00	120.00	150.00	180.00
4850	Miscarriage or abortion, less than six months; no surgery	10.0	26.00	32.50	36.50	30.00	37.50	45.00
4855	Miscarriage or abortion, including dilation and curettage	15.0	39.00	48.75	54.75	45.00	56.25	67.50
4914	Thyroidectomy, total or complete	60.0	156.00	195.00	219.00	180.00	225.00	270.00
4917	Thyroidectomy, subtotal or partial	50.0	130.00	162.50	182.50	150.00	187.50	225.00
4921	Hemithyroidectomy: lobectomy	30.0	78.00	97.50	109.50	90.00	112.50	135.00
4941	Excision of thyroglossal duct, cyst or sinus	40.0	104.00	130.00	146.00	120.00	150.00	180.00
5021	Laminectomy	80.0	208.00	260.00	292.00	240.00	300.00	360.00
5057	Spinal puncture: lumbar puncture (independent procedure)	3.0	7.80	9.75	10.95	9.00	11.25	13.50
5081	Encephalography (independent procedure)	15.0	39.00	48.75	54.75	45.00	56.25	67.50
5084	Myelography (independent procedure)	10.0	26.00	32.50	36.50	30.00	37.50	45.00
5171	Ventriculography (independent procedure)	20.0	52.00	65.00	73.00	60.00	75.00	90.00
5381	Sympathectomy: Lumbar, unilateral	50.0	130.00	162.50	182.50	150.00	187.50	225.00
5445	Removal of foreign body from cornea	3.0	7.80	9.75	10.95	9.00	11.25	13.50
5611	Extraction of lens, intracapsular or extracapsular, unilateral	70.0	182.00	227.50	255.50	210.00	262.50	315.00
5613	Extraction of lens, intracapsular, or extracapsular with preliminary iridectomy, unilateral	70.0	182.00	227.50	255.50	210.00	262.50	315.00

Procedure Code	DESCRIPTION	Relative Value	TOTAL "FAMILY" ANNUAL INCOME: Less Than $2,500	$2,500 $4,999	$5,000 $6,499	M-75 "SUBSCRIBER ONLY" INCOME: "A"	"B"	"C" & "D"
	UNIT VALUES USED		$2.60	$3.25	$3.65	$3.00	$3.75	$4.50
5641	Myotomy, tenotomy, recession, resection, advancement or shortening of ocular muscles for strabismus, one or more stages, unilateral	50.0	$130.00	$162.50	$182.50	$150.00	$187.50	$225.00
5642	bilateral	60.0	156.00	195.00	219.00	180.00	225.00	270.00
5702	Blepharectomy; excision of meibomian glands (chalazion), single	5.0	13.00	16.25	18.25	15.00	18.75	22.50
5961	Myringotomy: tympanotomy: plicotomy	2.0	5.20	6.50	7.30	6.00	7.50	9.00
5965	Stapes Mobilization	60.0	156.00	195.00	219.00	180.00	225.00	270.00
5975	Mastoidectomy, radical, unilateral	60.0	156.00	195.00	219.00	180.00	225.00	270.00
4801	Caesarean Section, classic	50.0	130.00	162.50	182.50	150.00	187.50	225.00
4802	low cervical (lower uterine segment)	50.0	130.00	162.50	182.50	150.00	187.50	225.00
4821	Obstetrical procedures: Obstetrical delivery	20.0	52.00	65.00	73.00	60.00	75.00	90.00

MEDICAL CARE

DURATION		TOTAL "FAMILY" ANNUAL INCOME: Less Than $2,500	$2,500 $4,999	$5,000 $6,499	M-75 "SUBSCRIBER ONLY" INCOME: "A"	"B"	"C" & "D"
	UNIT VALUES USED	$3.45	$4.35	$4.85	$4.00	$5.00	$6.00
1 Day		$ 8.63	$ 10.88	$ 12.13	$ 10.00	$ 12.50	$ 15.00
5 Days		22.43	28.28	31.53	26.00	32.50	39.00
10 Days		39.68	50.03	58.78	46.00	57.50	69.00
20 Days		74.18	93.53	104.28	86.00	107.50	129.00
30 Days		101.78	128.33	143.08	118.00	147.50	177.00
70 Days		212.18	267.53	298.28	246.00	307.50	369.00
120 Days		350.18	441.53	492.28	406.00	507.50	609.00

Hospital Days	Relative Value
1st day	2.5
2nd through 20th day	1.0
21st through 120th day	.8

RADIOLOGICAL DIAGNOSTIC SERVICES

Procedure Code	DESCRIPTION	Relative Value	TOTAL "FAMILY" ANNUAL INCOME: BENEFITS IDENTICAL ALL CONTRACTS	M-75 "SUBSCRIBER ONLY" INCOME: BENEFITS IDENTICAL ALL CONTRACTS
	UNIT VALUES USED		$4.35	$5.00
7010	Mandible, regular	2.0	$ 8.70	$10.00
7012	Mastoids, regular	3.0	13.05	15.00
7015	Facial bones	3.0	13.05	15.00
7016	Nasal bones	2.0	8.70	10.00
7020	Paranasal sinuses, regular	3.5	15.23	17.50
7026	Skull, complete	4.0	17.40	20.00
7100	Single PA	2.0	8.70	10.00
7101	Chest with multiple views	3.0	13.05	15.00
7110	Ribs, hemithorax including PA chest	3.0	13.05	15.00
7204	Spine, cervical	3.0	13.05	15.00
7207	Spine, thoracic	3.0	13.05	15.00
7210	Spine, lumbosacral	3.5	15.23	17.50
7211	Spine, lumbosacral with obliques	4.0	17.40	20.00
7214	Spine, sacro-coccygeal	3.0	13.05	15.00
7217	Pelvis, including hips	2.5	10.88	12.50
7250	Clavicle	2.0	8.70	10.00
7252	Shoulder	3.0	13.05	15.00
7253	Humerus, including one joint	2.0	8.70	10.00
7254	Elbow	2.0	8.70	10.00
7255	Forearm, including one joint	2.0	8.70	10.00
7256	Wrist	2.0	8.70	10.00
7257	Hand, including wrist	2.0	8.70	10.00
7258	Fingers	1.5	6.53	7.50
7301	Hip, complete, multiple positions	4.0	17.40	20.00
7303	Femur, including one joint	3.0	13.05	15.00
7304	Knee	2.5	10.88	12.50
7305	Leg, including one joint	2.0	8.70	10.00

Procedure Code	DESCRIPTION	Relative Value	TOTAL "FAMILY" ANNUAL INCOME BENEFITS IDENTICAL ALL CONTRACTS	M-75 "SUBSCRIBER ONLY" INCOME BENEFITS IDENTICAL ALL CONTRACTS
	UNIT VALUES USED		$4.35	$5.00
7306	Ankle	2.0	$ 8.70	$10.00
7307	Foot	2.0	8.70	10.00
7308	Toes	1.5	6.53	7.50
7350	Plain film study, not preceding gastro-intestinal combination	2.0	8.70	10.00
7358	Upper gastro-intestinal series	5.0	21.75	25.00
7359	Upper gastro-intestinal series with small bowel same day	7.0	30.45	35.00
7360	Colon by barium enema	5.0	21.75	25.00
7361	Barium enema with air contrast	6.0	26.10	30.00
7364	Cholecystography	4.0	17.40	20.00
7365	Cholangiography, operative or post-operative	5.0	21.75	25.00
7370	Kidney, ureter and bladder (abdomen plus detail view of renal areas)	2.5	10.88	12.50
7372	Pyelography, intravenous	6.0	26.10	30.00
7373	Pyelography, retrograde	4.0	17.40	20.00
7375	Cystography	3.0	13.05	15.00
7380	Abdomen and pelvis, plain for fetus, AP and lateral	3.0	13.05	15.00
7383	Pelvicephalometry	5.0	21.75	25.00

RADIOLOGICAL THERAPEUTIC SERVICES

PROVEN MALIGNANCY OR TUMORS

Super Voltage Fees are 125% of Deep

Procedure Code	DESCRIPTION	Relative Value	TOTAL "FAMILY" ANNUAL INCOME BENEFITS IDENTICAL ALL CONTRACTS		M-75 "SUBSCRIBER ONLY" INCOME BENEFITS IDENTICAL ALL CONTRACTS	
	UNIT VALUES USED		$4.35		$5.00	
			DEEP	SUPER VOLTAGE	DEEP	SUPER VOLTAGE
7500	Brain, including pituitary	35.0	$152.25	$190.31	$175.00	$218.75
7508	Nasopharyngeal, combined	55.0	239.25	299.06	275.00	343.75
7520	Intrathoracic Malignancy	35.0	152.25	190.31	175.00	218.75
7532	Stomach	20.0	87.00	108.75	100.00	125.00
7550	Kidney	35.0	152.25	190.31	175.00	218.75
7573	Cervix, radium insertion	25.0	108.75	135.94	125.00	
7582	Peritoneum, to include entire abdomen	40.0	174.00	217.50	200.00	250.00
7592	Postoperative	35.0	152.25	190.31	175.00	218.75
7596	Recurrent, chest wall	15.0	65.25	81.56	75.00	93.75
7600	Primary	35.0	152.25	190.31	175.00	218.75
7610	Leukemia, maximum per annum	60.0	261.00	326.25	300.00	
	minimum per treatment	2.0	8.70	10.88	10.00	
7612	Hodgkins, maximum per annum	80.0	348.00	435.00	400.00	500.00
	minimum per treatment	2.0	8.70	10.88	10.00	12.50
7616	Spinal cord lesions	35.0	152.25	190.31	175.00	218.75
7620	Skin neoplasm up to three cm. diameter	15.0	65.25	81.56	75.00	
7626	Endocrine system, pituitary, adrenal	20.0	87.00	108.75	100.00	125.00

ISOTOPE THERAPY

I. I^{131}						
7700	Benign—per annum	30.0	$130.50		$150.00	
7701	Malignant—per annum	50.0	217.50		250.00	
II. P^{32}						
A. Solution						
7710	Polycythemia vera, per treatment	10.0	43.50		50.00	
III. Au^{198}						
7730	Per Treatment	50.0	$217.50		$250.00	

ISOTOPES-DIAGNOSTIC STUDIES

7750	I^{131}—Tracer	10.0	$43.50		$50.00	
7751	I^{131}—Simple uptake study	5.0	21.75		25.00	
III.						
7761	Plasma blood volume	3.0	13.05		15.00	
V.						
7770	Red cell mass	5.0	21.75		25.00	
VI.						
7775	Fe^{59}—Turnover study	10.0	43.50		50.00	
VII.						
7780	Co^{60}—Vitamine B_{12} (Schilling) test	5.0	21.75		25.00	
VIII.						
7785	I^{131}—Diodrast renogram	6.0	26.10		30.00	

PATHOLOGICAL EXAMINATIONS

Procedure Code	DESCRIPTION	Relative Value	TOTAL "FAMILY" ANNUAL INCOME — BENEFITS IDENTICAL ALL CONTRACTS	M-75 "SUBSCRIBER ONLY" INCOME — BENEFITS IDENTICAL ALL CONTRACTS
	UNIT VALUES USED		$4.35	$5.00
8602	Agglutinations, for febrile diseases, first antigen	0.6	$ 2.61	$ 3.00
8618	Blood Culture definitive	2.0	8.70	10.00
8620	Blood, red cell count	0.4	1.74	2.00
8641	Calcium	1.0	4.35	5.00
8681	Hematocrit	0.5	2.18	2.50
8726	Sugar	0.8	3.48	4.00
8800	Occult blood	0.4	1.74	2.00
8828	Chemical, acid, fractional, with histamine	2.0	8.70	10.00
8901	Surgical, gross only	1.0	4.35	5.00
8934	Complete routine (chemical and microscopic)	0.4	1.74	2.00
8950	Electroencephalogram	5.0	21.75	25.00
8956	Basal metabolic rate	1.5	6.53	7.50
8957	Electrocardiogram, with interpretation and report	3.0	13.05	15.00
8967	Urinary 17-ketosteroids	2.0	8.70	10.00

CONSULTATION SERVICES

Procedure Code	DESCRIPTION	Relative Value	TOTAL "FAMILY" ANNUAL INCOME — Less Than $2,500	$2,500 $4,999	$5,000 $6,499	M-75 "SUBSCRIBER ONLY" INCOME — "A"	"B"	"C" & "D"
	UNIT VALUES USED		$3.45	$4.35	$4.85	$4.00	$5.00	$6.00
026	Consultation for a given system not requiring complete examination—in patient	2.0	6.90	$ 8.70	$ 9.70	$ 8.00	$ 10.00	$ 12.00
027	Consultation requiring complete examination—in patient	4.2	14.49	18.27	20.37	16.80	21.00	25.20
	TECHNICAL SURGICAL ASSISTANTS							
	UNIT VALUES USED		$2.60	$3.25	$3.65	$3.00	$3.75	$4.50
194	A fee for assistant, when eligible, to be placed at level of 15% of surgical fee, subject however, to minimum payments as follows:	6.0	$ 15.60	$ 19.50	$ 21.90	$ 18.00	$ 22.50	$ 27.00

September 25, 1960 EXHIBIT-4

Unit Values Established by Medical Care Insurance Committee and Passed by the Council of the Michigan State Medical Society.

Unit Values When Expressed in Terms of Gross Family Annual Earnings

	Surgical & Anesthesia	Medical Care	X-Ray and Diagnostic Services
Less than $2500	$2.60	$3.45	$4.35
$2500-4999 (5000)	$3.25	$4.35	$4.35
$5000-6499 (6500)	$3.65	$4.85	$4.35

THE SPEAKER: The report of Michigan Medical Service as printed, beginning on page 147 of the Handbook, including the supplemental report that Dr. McKean just gave will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

XI. SELECTION OF MICHIGAN'S FOREMOST FAMILY PHYSICIAN

THE SPEAKER: I will appoint Dr. Wunch as Chief Teller, Dr. Vanden Berg and Dr. Stander for any balloting that occurs during this session.

HAROLD A. FURLONG, M.D. [Oakland]: We would like to supplement the material appearing in the biography of Dr. George Raynale of Oakland County.

We would like to impress upon the House of Delegates that Dr. Raynale is the third member of a family to serve Oakland County over a period of 132 years—122 of those years have been by the family at Birmingham. We think that that is a very unusual record. Starting back when Michigan was a wilderness, the first Raynale came to Traverse City, Mich. There he was the postmaster. He was a state Senator and a member of the Constitutional Convention that set up the Constitution for the State of Michigan.

He moved to Birmingham in 1838, established a home there, raised a second Raynale that graduated in the first class of the old Detroit Medical College in 1869, went back to Birmingham and practiced with his father where the present George P. Raynale was born in 1880, and since that time Dr. Raynale for 58 years has served the people of Birmingham and of Oakland County with every tradition of the true family physician.

Oakland County is very proud to present to the House of Delegates the name of George P. Raynale as a candidate for selection as Michigan's Foremost Family Physician for 1960. Thank you.

GREGORY P. MOORE, M.D. [Wexford-Missaukee]: I should like to say in addition to the Grand Traverse-Leelanau-Benzie Society which is sponsoring Dr. Thirlby, that he has the enthsusiastic support of the members of the various counties in surrounding areas.

Many of us have known Dr. Thirlby for a good many years, and we are heartily in favor of his nomination.

One of the nicest things which Dr. Thirlby has done is to establish, along with Dr. Coller and Dr. Penberthy, the annual clinic which is held in July of each year in Traverse City. Dr. Coller and Dr. Penberthy have attended regularly until the death of the latter. Dr. Thirlby has always been enthusiastic in his promotion, and I might say that in this connection when he served as benefactor this actually included material provision of the meeting place, food and refreshments, and yet I am certain that I may speak freely in behalf of all those who know him when I state that he did this, not for personal or material or professional gain, but because of his sincere interest in medicine and those who practice it.

He has been prominent in civic affairs in many ways. In 1953 a community celebration was attended by several hundred friends and well-wishers honoring his fifty years of practice and service to the Grand Traverse area. Through his daily example and encouragement he has been a determining factor in the high standard of medical care now enjoyed by the Traverse region. He was one of the first to establish group practice. One of the physicians who is now associated with him is the delegate from this area. and were it not for that connection, no doubt he would be here making this nomination.

For these many varied and substantial reasons the Grand Traverse-Leelanau-Benzie Society as well as adjacent county societies proudly present for your consideration as Michigan's Foremost Family Physician of the Year, the name of Edward L. Thirlby. Thank you.

JOHN W. RICE, M.D. [Jackson]: Mr. Speaker, down the road about 75 miles on toward Chicago there is a whistle stop called "Jackson." It has been so long since Jackson has received any honors from the state society we have almost forgotten there is a state society, and you fellows have almost forgotten about us.

In 1948, Traverse City had a president of the state society. In 1951, Birmingham had a president of the state society. Jackson hasn't had a thing.

We have a real good candidate for the Foremost Family Physician. His name is C. D. Munro, and he is 90 years old. He is the oldest one of these three candidates. He is still in the practice of medicine, and he belongs to every doctor in Jackson County. We appeal for him. He is that kind of a guy. He has no enemies, believe me. I have known him all my life since I got out of high school. I have never heard anyone say a bitter thing about C. D. Munro. He is a gentleman from the word go.

He started in Jackson County, City of Jackson, in 1900. He was one of the charter members of the medical society there. He has been practicing there ever since. He was in the Army from 1917 to 1919. He has been a FACS since 1931, and he has a son practicing medicine in Jackson now, Nate Munro.

I certainly would like to have you vote for C. D. Munro, our candidate from Jackson.

[The ballots were cast and the tellers collected the ballots.]

We have the result of the balloting on Michigan's Foremost Family Physician. The winner, Doctor Thirlby.

Doctor Thirlby will be promptly notified of this honor, and we expect him to appear at some subsequent session of a meeting of the House.

HOMER A. HOWES, M.D. [Wayne]:

It is a great pleasure to introduce the medical students from the Medical Schools, from the University of Michigan and Wayne State University.

We have with us this morning three each from the senior class and three from the junior class. I will call out the names, and each one will stand.

PAT CARRIER, a senior from Three Rivers
DAVID DREW, a senior from Loveland, Colorado
DAVID TUBERGEN, a senior from Grand Rapids

Senior class representatives from Wayne State University College of Medicine:

JOSEPH LIIOI of Detroit
FRED SALAMON of Oak Park
JOHN C. RIENSTRA of Grand Rapids

The junior class representatives from the University of Michigan:

JOHN BALOG of Detroit
JOHN SIHORSKI of Detroit
CLIFF W. COLWELL of Flint

And the junior class representatives from Wayne:

DRAKE DUANE of Detroit
BRUCE DYBURZ of Detroit
STEVE GEORGIOU of Detroit

Also present is Thomas Schenk of St. Clair Shores.

THE SPEAKER:

The House of Delegates welcomes these young men to this session. I would like to say to them that they have freedom of movement at all the Reference Committees.

XII. RESOLUTIONS AND MOTIONS

W. CLARENCE BEETS, M.D. [Kent]:
Resolution No. 1
Introduced by Kent County Medical Society
Resolutions Committee

XII—1. MEDICAL CARE STUDY COMMITTEE

Whereas, twenty years ago, the Michigan State Medical Society embarked on a social experiment of prepaid insurance for medical services for low income groups, and

Whereas, the following social and economic changes in the United States and specifically the State of Michigan, having influenced this program are:

1. Changing concepts of responsibility in "cradle to grave" care.
2. Inflation and higher cost of living.
3. Acceptance of principles of prepaid medical insurance by buying public.

4. Increasing popularity of medical services due to availability.
5. Increasing popularity due to advances in medical science.
6. Increasing usage of prepaid medical services by "labor" as fringe benefits.
7. Widening scope of governmental agencies in medical services, and

Whereas, these facts have continually expanded and there is little likelihood of their regressing, and

Whereas, this has projected the medical profession into the complexities of the business world, and

Whereas, this has caused many divergent opinions and conflicting views amongst physicians which has kept the development of prepaid plans several years behind the demands of labor, industry and general public, and

Whereas, physicians and the Michigan Medical Service have sacrificed economically and socially by:

1. Not being able to acquire sufficient premiums to cover usage,
2. Increased fees comparable to cost of living index,
3. Public relations and prestige, therefore be it

RESOLVED: That the Michigan State Medical Society appoint a committee to extensively study by whatever and all means available:

1. The projected needs and likely demands on medical services during the next 15 years.
2. To study the feasibility and advise whether or not the Michigan State Medical Society under these projected needs carry on a prepaid medical insurance program.
3. If so, whether this is to be a limited so-called "service" program or more.
4. Recommend as to the best means to achieve this goal, and be it further

RESOLVED: That the study be completed no later than the 1962 meeting of the House of Delegates.

THE SPEAKER: This resolution as slightly amended will be referred to the Resolutions Committee.

THOMAS J. DILLON, M.D. [Van Buren]:
Resolution No. 2
Introduced by Van Buren County Medical Society
Legislation and Public Relations Committee

XII—2. ELECTION CAMPAIGNS

Whereas, the Michigan State Medical Society has firmly gone on record that political medicine is bad for you and is bad for the nation, and

Whereas, any compromise with the proponents of political medicine is partial surrender of American heritage, and

Whereas, the Forand Bill or similar legislation is an introduction of political medicine and another step in bureaucratic control of independent thought in medical care, and

Whereas, the most important step in gaining control of a nation is control of the health matters of that nation as so stated by the founders of communism, and

Whereas, it therefore follows that any individual Senator, Representative or other selected or hired office holder as a proponent of such an idea, either in state or national office is bad for the nation, therefore be it

RESOLVED: That we go on record to individually work towards the defeat of these state and national candidates who either through political expediency or through conscious or subconscious desire to gain power are promulgating these socialistic and foreign ideas into our American heritage.

THE SPEAKER: This resolution will be referred to Legislation and Public Relations.

ROSS V. TAYLOR, M.D. [Jackson]:
Resolution No. 3
Introduced by Jackson County Medical Society
Medical Service and Prepayment Insurance Committee

XII—3. DESCRIPTIVE CODING OF MEDICAL SERVICES

Whereas, there is an increasing utilization of, and therefor need for, detailed descriptive coding or listings of the services offered in medical care, and

Whereas, these descriptive codings may be used as the basis of contractural negotiations between the Michigan State Medical Society and various state and national governmental agencies as well as various prepayment plans of medical care, including Michigan Medical Service, and

Whereas, to date, there has been inadequate descriptive coding of the varied and numerous nonsurgical services of medical care, and

Whereas, the lack of adequate descriptive coding of nonsurgical services of medical care will cause a deterioration in the quality and availability of such medical services unless they are satisfactorily coded and included in all listings of medical services, therefore be it

RESOLVED: That the Michigan State Medical Society immediately study and develop more detailed codings of the non-surgical services of medical care based on the diagnosis and treatment of the ailment and comparable in detail to existing codings of surgical services, and to include home, hospital, and office procedures, and be it further

RESOLVED: That the detailed codings of non-surgical services, home, hospital and office as soon as developed, shall be incorporated and used as the basis of the description of such services in all negotiations with state or national governmental agencies and all prepayment insurance plans involved in supplying medical service, or the reimbursement of costs of medical care, and be it further

RESOLVED: That the Michigan State Medical Society shall establish a means of continuing study of the adequate detailed coding of all medical care so that new procedures and additional descriptions both surgical and nonsurgical may be coded and more quickly incorporated into all schedules which depend on such descriptive coding for the supplying of reimbursement of costs of medical care.

THE SPEAKER: This will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

WILLIAM F. BUCHANAN, M.D. [Genesee]:
Resolution No. 4
Introduced by Genesee County Medical Society
Medical Service and Prepayment Insurance Committee

XII—4. BLUE SHIELD POLICY

Whereas, the individual members of the Genesee County Medical Society have been requested at various times by members of the Professional Relations Committee of Blue Shield to point out its failures and mistakes, and

Whereas, the Genesee County Medical Society as a large component of the State Society servicing more Blue Shield subscribers per capita than any other county, wishes to state our position in relation to Blue Shield, and

Whereas, this resolution was adopted by the Genesee County Medical Society at its regular meeting on September 8, 1960 and respectfully submitted to the delegates of the Michigan State Medical Society, and

Whereas, direct patient-physician relationship without third party intervention has given the people of this county the highest type of medical service, and

Whereas, the Committee for Evaluation has studied this problem thoroughly and made definite recommendation, and

Whereas, the Genesee County Medical Society has always believed in the principle of prepayment medical insurance on a partial indemnity basis, but not in the form

of fee for services, which the Genesee County Medical Society believes is self-socialization, and

Whereas, we are opposed to any intermediate that imposes restrictions or regulations on either the doctor or patient by a third party, and

Whereas, the Genesee County Medical Society has never opposed prepaid health insurance on a partial indemnity basis and the members of the Society have always cooperated with any insurance company, including Michigan Medical Service, so long as that company did not violate the principles as stated above, and

Whereas, the Genesee County Medical Society is cognizant of the mandatory high cost to the subscriber and continually rising premiums as additional benefits are being added, and

Whereas, under the present system the patient finds it to their financial advantage and convenience to be cared for in hospital beds and especially the emergency room, and

Whereas, there are many people who find it expedient to criticize the medical profession for so-called over-utilization, and

Whereas, the Insurance Commissioner's report of June 15, 1960 relative to the raising of premiums to Blue Shield subscribers shows that medical services rendered under the present Blue Shield system are under governmental and/or political control, and

Whereas, other states have partial indemnity policies, therefore be it

RESOLVED: That Genesee County Medical Society firmly believes that prepayment health insurance on a partial indemnity or deductible basis should be adopted throughout the State of Michigan, and be it further

RESOLVED: That the Genesee County Medical Society endorse the report of the Committee for Evaluation and recommend its adoption, and be it further

RESOLVED: That Genesee County Medical Society believes that failure of the House of Delegates to act on the above decisions, and failure to exercise the above-mentioned recommendations, will mean frequent stop gap changes to appease the public and powerful pressure groups (to keep Blue Shield solvent) thereby leading to chaos, and finally in desperation, to a request from misguided public and a frustrated profession, for full government control of medical practice.

THE SPEAKER: This resolution will be referred to the Medical Service and Prepayment Insurance.

PAUL T. LAHTI, M.D. [Oakland]:
Resolution No. 5
Introduced by Oakland County Medical Society
Miscellaneous Business Committee

XII—5. LOAN FUND FOR NEW PHYSICIANS

Whereas, some physicians in Michigan on completing their internship or residency, need financial help to establish themselves in the private practice of medicine, and

Whereas, this lack of funds may encourage some physicians to accept panel type of practice rather than private practice, therefore be it

RESOLVED: That the Michigan State Medical Society make funds available at a low interest rate to such physicians beginning private practice in Michigan.

THE SPEAKER: This resolution will be referred to Miscellaneous Business.

ROBERT M. BOOKMYER, M.D. [Oakland]:
Resolution No. 6
Introduced by Oakland County Medical Society
Medical Service and Prepayment Insurance Committee

XII—6. HOSPITAL EMERGENCY CARE

Whereas, hospital emergency room care of non-emergency patients has grown at an alarming rate, and

Whereas, these patients are seen by interns and residents, and

Whereas, such care constitutes the practice of medicine by the hospital, and

Whereas, the trend toward hospital emergency room clinic practice is being fostered by prepayment plans which do not pay for the same service when rendered in the private doctor's office, therefore be it

RESOLVED: That the Michigan State Medical Society undertake a study to develop means whereby such "emergency care" can be carried out within the framework of the private practice of medicine, and be it further

RESOLVED: That the Michigan State Medical Society recommend to the Michigan Hospital Service that it discontinue the practice of paying for routine clinic care in hospital emergency rooms.

THE SPEAKER: This resolution will be referred to the Reference Committee on Medical Service and Prepayment.

ROBERT M. STOW, M.D. [Ingham]:
Resolution No. 7
Introduced by Ingham County Medical Society
Legislation and Public Relations Committee

XII—7. REPEAL BASIC SCIENCE LAW

Whereas, the original purpose of basic science laws was to exclude from licensure inadequately trained practitioners, and

Whereas, Act No. 59 of the Public Acts of 1937 of the State of Michigan, usually called the Basic Science Law, has failed in this purpose, and

Whereas, the Basic Science Law is a major factor in causing Michigan's critical shortage of Doctors of Medicine, therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society go on record as favoring repeal of the Basic Science Law, and be it further

RESOLVED: That the Council of the Michigan State Medical Society be instructed to have legislation to accomplish this repeal introduced into the Legislature of the State of Michigan during its 1961 session and to vigorously press for repeal of the Basic Science Law.

THE SPEAKER: This will be referred to the Reference Committee on Legislation and Public Relations.

R. WALLACE TEED, M.D. [Washtenaw]:
Resolution No. 8
Introduced by Washtenaw County Medical Society
Legislation and Public Relations Committee

XII—8. WAGES OF NURSES

Whereas, the annual income of registered nurses is less than that received by women in other activities such as teaching, and

Whereas, women in fields requiring less preparation often receive higher salaries, and

Whereas, there has been developing a shortage of trained nurses in recent years largely due to low salaries of nurses, and

Whereas, recruitment of young women for nursing training is becoming difficult because wages and salaries are higher in other areas of employment, therefore be it

RESOLVED: That the House of Delegates of the

Michigan State Medical Society go on record as favoring an increase in salaries for registered nurses.

R. Wallace Teed, M.D. [Washtenaw]:
Resolution No. 9
Introduced by Washtenaw County Medical Society
Legislation and Public Relations Committee

XII—9. NURSES TRAINING PROGRAM

Whereas, there has been a tendency in recent years for schools of nursing to emphasize academic training and the receipt of academic degrees, and

Whereas, there has been a concomitant shortage in the supply of trained nurses to carry on the operation of of hospitals, and

Whereas, the training of practical nurses has been instituted as a stopgap procedure, therefore be it

RESOLVED: That schools of nursing be encouraged to study all aspects of the problem of the nursing shortage, to the end that there may be available for patient care more nurses trained in the practical aspects of nursing.

The Speaker: Resolutions No. 8 and 9 will be referred to the Reference Committee on Legislation and Public Relations.

John R. Heidenreich, M.D. [Menominee]:
Resolution No. 10
Introduced by Menominee County Medical Society
Constitution and Bylaws Committee

XII—10. POSTGRADUATE MEDICAL EDUCATION COMMITTEE MEMBERSHIP

Whereas, a resolution calling for the reduction from thirteen to seven members, including the chairman, on the Committee on Postgraduate Medical Education, has been introduced by the House of Delegates Reference Committee, and tabled until the 1960 session of the House, and

Whereas, the successful functioning of the committee since 1927 and recent extensive discussions indicate the need of the present membership to provide wide geographic and educational representation for the purpose of planning and implementing postgraduate medical education programs to meet the needs and desires of the state profession as recipients of postgraduate medical education, and

Whereas, there is indicated agreement that the committee should not be reduced in the number of membership so that broad representation and needed advice may be continued, therefore be it

RESOLVED: That the Committee on Postgraduate Medical Education should consist of a chairman in addition to twelve members; that the chairman should be the director of the department of postgraduate medicine at one of the medical schools in the state; that among the members should be included the heads of the Department of Postgraduate Medical Education for each of Michigan's schools of medicine; and be it further

RESOLVED: That the deans of each medical school, the past chairman of the Committee on Postgraduate Medical Education, and a representative of the Michigan Department of Health should be invited to serve in an advisory capacity; and be it further

RESOLVED: That four of the twelve members should be appointed each year to serve for a three-year term.

The Speaker: This Resolution will be referred to the Committee on Constitution and Bylaws.

David A. Bowman, M.D. [Bay-Arenac-Iosco]:
Resolution No. 11
Introduced by Bay-Arenac-Iosco County Medical Society
Constitution and Bylaws Committee

XII—11. MICHIGAN STATE MEDICAL SOCIETY COUNCILORS—MEMBERS OF HOUSE OF DELEGATES

Whereas, the Michigan State Medical Society House of Delegates Committee to study the Election of Councilors on a geographic basis and the status of Councilors as voting members of the House of Delegates recommends that Michigan State Medical Society Councilors be made members of the House of Delegates at large with the right to vote, therefore be it

RESOLVED: That Chapter 9, Section 1 of the Michigan State Medical Society Bylaws be amended by adding the words "and Councilors" after the word "societies" in the first sentence, and be it further

RESOLVED: That Chapter 9, Section 2 of the Michigan State Medical Society Bylaws be amended so that the first sentence will read: "Officers of this state society shall be ex officio members at large of the House of Delegates, with the privilege of the floor, but of these, only the Councilors and the Speaker and Vice Speaker of the House of Delegates shall have the power to vote in the House of Delegates," and be it further

RESOLVED: That Chapter 10, Section 2 of the Michigan State Medical Society Bylaws be amended by adding the following: "He shall serve as delegate at large in the House of Delegates."

David A. Bowman, M.D. [Bay-Arenac-Iosco]:
Resolution No. 12
Introduced by Bay-Arenac-Iosco County Medical Society
Constitution and Bylaws Committee

XII—12. MICHIGAN STATE MEDICAL SOCIETY COUNCILORS—ELECTIONS

Whereas, the Michigan State Medical Society House of Delegates Committee to Study the Election of Councilors on a geographic basis and the status of Councilors as voting members of the House of Delegates recommends that Councilors be selected by popular vote in their districts, therefore be it

RESOLVED: That Chapter 9, Section 10(g) of the Michigan State Medical Society Bylaws be amended to read as follows: "(g) It shall name the Councilors upon the election of same by the members of the Councilor District whose Councilor's term expires, or by the delegates of the district in the event a vacancy occurs during an annual session, as hereinafter provided.

"In every district whose Councilor's term is to expire at the time of the annual session the Secretary of the state society shall, under the direction of The Council, solicit nominations for the office from the members of the district, conduct a general mail ballot of the members on the nominations, and report the results of the same to the House of Delegates.

"The House of Delegates shall certify the results of the balloting and upon a determination of the majority vote of the members of the district, shall declare the winner to be the Councilor for the ensuing term.

"If a vacancy in The Council occurs during an annual session of the Michigan State Medical Society the delegates of the component county societies will be given time in which to elect a successor to serve the remainder of the term."

David A. Bowman, M.D. [Bay-Arenac-Iosco]:
Resolution No. 13
Introduced by Bay-Arenac-Iosco County Medical Society
Constitution and Bylaws Committee

XII—13. MICHIGAN STATE MEDICAL SOCIETY COUNCILORS—TERM OF OFFICE

Whereas, the Michigan State Medical Society House of Delegates Committee to Study the Election of Councilors on a geographic basis and the status of Councilors as voting members of the House of Delegates recommends that the term of office of MSMS Councilors be three years with the privilege of re-election, it being intended that the terms of office of present Councilors should not be affected, therefore be it

RESOLVED: That Chapter 12, Section 1 of the Michigan State Medical Society Bylaws be amended so that the second sentence will read: "They shall serve until the next annual session provided that Councilors elected prior to 1960 shall serve for five years, but Councilors elected in 1960 and after shall serve for three years (and provided that not more than eight Councilor terms shall expire normally at any annual session); provided further that delegates to the American Medical Association shall serve for two years; provided further that not more than four delegates to the American Medical Association shall be elected in any one year."

THE SPEAKER: These three resolutions will be referred to the Reference Committee on Constitution and Bylaws.

LOUIS J. BAILEY, M.D. [Wayne]:
Resolution No. 14
Introduced by Wayne County Medical Society
Constitution and Bylaws Committee

XII—14. PETITION FOR REVOCATION OF CHARTER: CLARIFICATION OF MICHIGAN STATE MEDICAL SOCIETY BYLAWS

Whereas, Chapter 1, Section 2 is in one small particular ambiguous, therefore be it

RESOLVED: That Chapter 1, Section 2 be changed to read in its second sentence:

From: "Petition for the revocation of charter of any component county society may be filed with The Council by a Councilor of the district within which each society is located." and so forth.

To: "Petition for the revocation of charter of any component county society may be filed with The Council by a Councilor of the district within which such society is located," and so forth.

THE SPEAKER: This resolution will be referred to the Reference Committee on Constitution and Bylaws.

JACK ROM, M.D. [Wayne]:
Resolution No. 15
Introduced by Wayne County Medical Society
Miscellaneous Business Committee

XII—15. RENAME MICHIGAN STATE MEDICAL SOCIETY SECTION ON MEDICINE

Whereas, the interests of many specialty and sub-special groups are represented by the Section on Medicine of Michigan State Medical Society, and

Whereas, the designation "Medicine" is ambiguous and subject to misinterpretation, therefore be it

RESOLVED: That the name "Section of Medicine" be changed to "Section on Internal Medicine."

THE SPEAKER: This will be referred to the Committee on Miscellaneous Business.

GEORGE J. MORIARTY, M.D. [Wayne]:
Resolution No. 16
Introduced by Wayne County Medical Society
Miscellaneous Business Committee

XII—16. UNIFORM TRANSFER OF MEMBERSHIP

Whereas, there is a lack of uniformity in procedure for transfer of membership from one county and state society to another, and

Whereas, the financial arrangements for proration of dues between county and state societies are not of a uniform nature, and

Whereas, this has created some difficulties in the transfer of membership, particularly from one state to another, therefore be it

RESOLVED: That national uniform procedures for transfer of membership be adopted, and be it further

RESOLVED: That the Michigan delegates of the American Medical Association be urged to present this resolution at the next meeting of the American Medical Association House of Delegates.

THE SPEAKER: It will be referred to the Committee on Miscellaneous Business.

RALPH A. JOHNSON, M.D. [Wayne]:
Resolution No. 17
Introduced by Wayne County Medical Society
Resolutions Committee

XII—17. APPOINTMENT OF MICHIGAN STATE MEDICAL SOCIETY HISTORIAN

Whereas, it would be to the best interest of the Michigan State Medical Society to have a historical record of its distinguished past and distinguished future, therefore be it

RESOLVED: That the House of Delegates request The Council to appoint a historian for the Michigan State Medical Society.

THE SPEAKER: This has been referred to the Committee on Resolutions.

LOUIS J. BAILEY, M.D. [Wayne]:
Resolution No. 18
Introduced by Wayne County Medical Society
Constitution and Bylaws Committee

XII—18. CONSISTENCY OF COUNTY—MSMS BYLAWS

Whereas, reasonable autonomy is to be given to each component medical society, and

Whereas, certain variations in conduct of their business is to be expected because of differences in size, dispersion of members and the closeness of personal contact between members, and

Whereas, some tendency has been apparent within county societies to fear the slightest deviation from the exact wording of the Constitution and Bylaws of the Michigan State Medical Society, therefore be it

RESOLVED: That Chapter 1, Section 1 of the Bylaws of the Michigan State Medical Society be changed:

From: "The charter of each component County Society shall require that each of the provisions of the Constitution and Bylaws of the Michigan State Medical Society, together with each amendment to either thereof, hereafter adopted, in so far as the same is applicable, shall be an integral part of the Constitution and Bylaws of the component county society to which a charter is issued and shall in no way be inconsistent with the Constitution and Bylaws of the Michigan State Medical Society. Each charter shall be authorized by the House of Delegates and signed by the President and the Secretary of this Michigan State Medical Society."

To: "The charter of each component county society shall be authorized by the House of Delegates and signed by the President and Secretary of this Michigan State Medical Society. Each component society shall require that the provisions of its Constitution and Bylaws shall be consistent with the Constitution and Bylaws of the Michigan State Medical Society together with any amendments hereafter adopted, in so far as the same is applicable."

THE SPEAKER: This will be referred to the Reference Committee on Constitution and Bylaws.

LOUIS J. BAILEY, M.D. [Wayne]: This Resolution also has to do with Councilor districts.

XII—44. COUNCILOR DISTRICTS

Whereas, The Council of the Michigan State Medical Society is the executive body of the Society; and

Whereas, it acts for the Society as a whole and for the House of Delegates between sessions; and

Whereas, it is essentially in these capacities an unicameral legislative body, the composition of which should bear some relationship in its apportionment to the composition of the House of Delegates for which it acts; and

Whereas, reappointment of the Council districts with growth of population is unwieldy; therefore be it

RESOLVED: That Article X, Section 1 of the Constitution of the Michigan State Medical Society be amended in its second sentence: From: "It shall consist of one Councilor from each Councilor district," and so forth;

To: "It shall consist of one Councilor from each Councilor district or one Councilor for each ten delegates when the number of delegates from a district exceeds ten," and so forth, and be it further

RESOLVED: That Chapter X, Section 12 of the Bylaws of the Michigan State Medical Society be amended to delete the Sixteenth, Seventeenth and Eighteenth Districts now alloted to Wayne County.

THE SPEAKER: This Resolution will be referred to the Reference Committee on Constitution and Bylaws.

RALPH R. COOPER, M.D. [Wayne]:
Resolution No. 19
Introduced by Wayne County Medical Society
Resolutions Committee

XII—19. MSMS COUNCILORS HOLDING TWO POSITIONS

Whereas, there may be a conflict of interest between the doctors of medicine and Michigan Medical Service, and

Whereas, in the past, members have served as directors of Michigan Medical Service while serving as Councilors of the Michigan State Medical Society, therefore be it

RESOLVED: The members of The Council of the Michigan State Medical Society should not hold simultaneous Board Membership in Michigan Medical Service.

THE SPEAKER: This has been referred to the Committee on Resolutions.

Resolution No. 20 regarding Election of Secretary by the Michigan State Medical Society. This actually was Resolution No. 44 of the 1959 House of Delegates and is an amendment to the Constitution and was laid over for one year. So Resolution No. 20 will be automatically referred to the Constitution and Bylaws Reference Committee.

Resolution No. 20
(Resolution No. 44, 1959 Session)
Constitution and Bylaws Committee

XII—20. ELECTION OF MSMS SECRETARY

Whereas, The Council of the Michigan State Medical Society is empowered to act on behalf of the Society in the interim between sessions of the House of Delegates, and

Whereas, each Council member should be elected by the delegates who are the elected representatives of the membership, and

Whereas, the Secretary who is a member of the Executive Committee of The Council is elected by The Council, therefore be it

RESOLVED: That the Secretary be elected annually by the House of Delegates, and be it further

RESOLVED: That Article X, Section 1 of the Constitution be amended by striking out after Secretary and Treasurer, the following "the last two being elected by the foregoing," and be it further

RESOLVED: That provisions of Article XII, Section 1 of the Constitution be implemented as provided.

THE SPEAKER: Resolution 21 having to do with the Election of Treasurer also was Resolution No. 45 of the 1959 House. It is an amendment to the Constitution and was laid over for one year. This is referred to the Committee on Constitution and Bylaws.

Resolution No. 21
(Resolution No. 45, 1959 Session)
Constitution and Bylaws Committee

XII—21. ELECTION OF MSMS TREASURER

Whereas, The Council of the Michigan State Medical Society is empowered to act on behalf of the Society in the interim between sessions of the House of Delegates, and

Whereas, each Council member should be elected by the delegates who are the elected representatives of the membership, and

Whereas, the Treasurer, who is a member of the Executive Committee of The Council is elected by The Council, therefore be it

RESOLVED: That the Treasurer be elected annually by the House of Delegates, and be it further

RESOLVED: That Article X, Section 1 of the Constitution be amended by striking out after Secretary and Treasurer, the following "the last two being elected by the foregoing," and be it further

RESOLVED: That provisions of Article XII, Section 1 of the Constitution be implemented as provided.

THE SPEAKER: Resolution No. 22 having to do with the membership of the Committee on Postgraduate Medical Education was Resolution No. 51 of the 1959 House of Delegates. This was an amendment to the Bylaws, but by a motion was tabled for one year, and now automatically is referred to the Committee on Constitution and Bylaws.

Resolution No. 22
(Resolution No. 51, 1959 Session)
Constitution and Bylaws Committee

XII—22. COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

Whereas, the report of the Committee on Committees has recommended to the Society that streamlining of the Committee structure of the Society be accomplished, therefore be it

RESOLVED: That the following changes be made in Chapter 11, Section 2 of the Bylaws concerning the Committee on Postgraduate Medical Education to wit: "The Committee on Postgraduate Medical Education shall consist of seven members including the chairman with the

deans of two medical schools acting in an advisory capacity. Each member of this committee is to serve for a four-year term so staggered that not more than two members are selected annually and so that no member shall serve more than two consecutive terms."

THE SPEAKER: Resolution No. 23 regarding the Voting Power of Secretary and Treasurer of Michigan State Medical Society is an amendment to the Constitution and was Resolution No. 52 of the 1959 House of Delegates. This resolution will be referred to the Constitution and Bylaws Committee.

Resolution No. 23
(Resolution No. 52, 1959 Session)
Constitution and Bylaws Committee

XII—23. VOTING POWER OF SECRETARY AND TREASURER OF MSMS

Whereas, the nature of the positions of Secretary and Treasurer in the Michigan State Medical Society is such that continuity of service is desirable, and

Whereas, it would be to the disadvantage of the Michigan State Medical Society to change these officers frequently, and

Whereas, the Secretary and Treasurer of the Michigan State Medical Society are not directly elected by the members of the House of Delegates, therefore be it

RESOLVED: That the Constitution of the Michigan State Medical Society be amended by the addition of Section 3 to Article X reading: "The Secretary and Treasurer shall not be entitled to vote while serving on The Council of the medical society or the Executive Committee of The Council."

R. WALLACE TEED, M.D. [Washtenaw]:
Resolution No. 24
Introduced by Washtenaw County Medical Society
Miscellaneous Business Committee

XII—24. EMPLOYEE RECOGNITION

Whereas, it is a common practice among associations and in industry to recognize long and faithful services of employes, and

Whereas, the Michigan State Medical Society enjoyed a continuity of service from an unusually high percentage of its employes and has profited thereby, and

Whereas, recognition of salutary services of these employes will add to the esprit de corps of all employed personnel if such recognition is established on a permanent basis for all levels of employment, therefore be it

RESOLVED: That the Council of the Michigan State Medical Society be authorized to cause insignia to be designed specifying the number of years of service in MSMS employment and that this insignia be given to its employes accompanied on anniversary dates of five-year intervals by a gift of $10 for each year of service and that these awards be publicly presented upon proper occasions, and be it further

RESOLVED: That this system of awards be established beginning with the conclusion of the calendar year of 1960 and recognize service prior to and including that date to the nearest anniversary of employment.

THE SPEAKER: This resolution will be referred to the Committee on Miscellaneous Business.

G. B. SALTONSTALL, M.D. [Delegate at Large]:
Resolution No. 25
Introduced by G. B. Saltonstall, M.D.
Legislation and Public Relations Committee

XII—25. THE INSTITUTING OF A PRESIDENTS PROGRAM

Whereas, the challenge of today to the medical profession is to revitalize the unique power of the individual doctor to serve the whole person in sickness and in health, and

Whereas, to gain maximum benefit from the monumental gains of modern medical research it is necessary that the research findings be applied at the earliest opportunity to the maximum number of persons who could benefit by these new drugs, treatments, techniques or concepts of medical and health care and

Whereas, the medical profession wishes to join with those segments of the public which are primarily concerned with health (as well as with all persons or groups who can make effective contributions to the general public health), as partners in a single, well-defined health program, and

Whereas the Michigan State Medical Society which has pointed with pride over the past 95 years to separate individual "firsts" in medically-oriented activity, can now evidence the same willingness to serve the public interest by offering its leadership in a single, well-conceived and executed, integrated program, therefore be it

RESOLVED: That a five-year project be inaugurated by the Michigan State Medical Society specifically designed to utilize to the fullest extent:

A. The capabilities and knowledge of its individual members as leaders,

B. The facilities of its new headquarters as a "Campaign Control Center" and

C. Its staff and resources as communicating and coordinating services toward the end of expediting plans which will (Reference Committee added these words) hope to:

1. Result in an increase of five years in the general life expectancy of the people of Michigan, said increase to be accomplished (the word "accomplished" was changed to "attempted" by the Reference Committee) over the period of time beginning in September 1960 and concluding in September 1965 (the 100th anniversary of the Michigan State Medical Society), and

2. Increase the potential productivity and usefulness of those additional five years of life; and be it further

RESOLVED: That to accomplish this goal the Council of the Michigan State Medical Society be empowered and urged to:

A. Seek the advices, aid and assistance of all members of the Michigan State Medical Society, as well as all related sciences, and the enthusiastic support of its county and district medical societies,

B. Support all reasonable efforts to place the latest developments of research into the armamentarium of the doctors of medicine of Michigan at the earliest possible date,

C. Request the assistance of and coordinate its work and recommendations with those qualified voluntary and governmental agencies to gain a maximum amount of progress toward the goal with a minimum of duplication of effort; and be it further

RESOLVED: That this effort be carried out at the top level of organizational work and to that end this project be headed (the word "headed" was changed to "promoted" by the Reference Committee) by each succeeding President of the Michigan State Medical Society during the next five years who will work in conjunction with the titular heads of all other pertinent organizations; and be it further

RESOLVED: That this project be known as the Presidents Program.

THE SPEAKER: This resolution will be referred to the Committee on Legislation and Public Relations.

THE SPEAKER: Resolutions No. 25 through No. 38 will be referred to the Committee on Legislation and Public Relations.

JOSEPH G. MOLNER, M.D. [Wayne]:
Resolution No. 26
Introduced by G. B. Saltsonstall, M.D.
Co-introduced by J. G. Molner, M.D., of Wayne County Medical Society
Legislation and Public Relations Committee

XII—26. PRESIDENTS PROGRAM: PUBLIC HEALTH, FULL TIME LOCAL UNITS

Whereas, adequate Public Health facilities and personnel at local, state and national levels are vital to the health of the people, and

Whereas, all areas of Michigan are not served by full time local health departments, and

Whereas, many lives can be saved and much disease prevented by improvement of sanitation, halting of the spread of infectious disease, adequate health screening of migrant workers, widespread health education and other essential health services; therefore be it

RESOLVED: That the President's Program of the Michigan State Medical Society include an effort to promote the securing of complete coverage of this state by full time local health departments, and be it further

RESOLVED: That the assistance of the following named groups, as well as any others of like mind, be sought in the gaining of the desired end:

The Michigan Department of Health
The Michigan Association of Health Officers
The Michigan Public Health Association
The Michigan Health Council
The Michigan State Dental Association
The Michigan State Association of Veterinary Medicine
The Michigan State Nurses Association
The Michigan Association of the Professions
All component District and County Medical Societies

H. CLAY TELLMAN, M.D. [Muskegon]:
Resolution No. 27
Introduced by G. B. Saltonstall, M.D.
Co-introduced by H. Clay Tellman, Muskegon County Medical Society
Legislation and Public Relations Committee

XII—27. PRESIDENTS PROGRAM: BASIC RESEARCH

Whereas, history proves that basic advances in medicine come only through the route of basic research, of which the discovery of penicillin is one example, and

Whereas, although clinical research attempts to solve specific disease problems and provide valuable contributions to methods of medical treatment major breakthroughs in basic medical knowledge are accomplished, in the main, as a result of basic research, and

Whereas, scientists the nation over as well as medical schools, lament the fact that so great a proportion of available funds are for limited research, therefore be it

RESOLVED: That the Michigan State Medical Society incorporate in its President's Program an effort to inform the public of the need for unrestricted research grants and to encourage individuals, foundations and government agencies to direct their funds for basic research, and be it further

RESOLVED: That the following organizations and others of like mind, be requested to cooperate with Michigan State Medical Society in this program:

University of Michigan
Wayne State University
University of Detroit
Michigan State University
Research Foundations—both state and national

J. PAUL KLEIN, M.D. [Newaygo]:
Resolution No. 28
Introduced by G. B. Saltonstall, M.D.
Co-introduced by J. P. Klein, M.D., Newaygo County Medical Society
Legislation and Public Relations Committee

XII—28. PRESIDENTS PROGRAM: MATERNAL AND CHILD HEALTH

Whereas, despite remarkable progress in the lowering of rates of maternal mortality, maternal deaths are still a medical problem in Michigan, and

Whereas, means exist in modern medical practice whereby the rate of maternal mortality may be lowered still further if appropriate information regarding maternal health is disseminated to the medical profession and the lay public; therefore be it

RESOLVED: That the Presidents Program of the Michigan State Medical Society include a program providing for the following:

1. Expansion of the use of the perinatal mortality register.
2. The institution of county medical society maternal health committees in those counties where they do not presently exist, and the stimulation of these committees in those societies where such committees do exist.
3. The development of expectant parent classes and other varieties of instruction beginning in the secondary schools and extending up to and including adult education programs.
4. Continuing publication in THE JOURNAL, MSMS, of Obstetrical Brevits and other scientific materials regarding maternal and child health and the distribution of information of an appropriate nature through news media and other publications to the lay public; and be it further

RESOLVED: That the following organizations, and others of like mind be requested to cooperate with Michigan State Medical Society in this program:

Michigan Department of Health
Michigan Association of Public Health Officers
Michigan Department of Public Instruction
Michigan Academy of Pediatrics and other specialty organizations

J. LEONIDAS LEACH, M.D. [Genesee]:
Resolution No. 29
Introduced by G. B. Saltonstall, M.D.
Co-introduced by J. Leonidas Leach, M.D., Genesee County Medical Society
Legislation and Public Relations Committee

XII—29. PRESIDENTS PROGRAM: PREVENTION OF DISEASE

Whereas, the prevention of disease is a medical responsibility of equal importance to the curing of disease, and

Whereas, success in disease prevention requires the cooperation of the private practitioner of medicine as well as public health officials, voluntary health agencies and community leaders, and

Whereas, many efforts now being made can be enhanced by renewed activity and new approaches to the solution of problems as is indicated by such examples as the following:

Because, if present rates continue, lung cancer will claim the lives of one million American children now in our schools;

Because, 23 studies in eight countries have shown that lung cancer patients are predominantly cigarette smokers;

Because, lung cancer cure rates are one in twenty, the American Cancer Society is conducting a nationwide educational program for teen-agers on cigarettes and lung cancer; and

Whereas, polio, venereal disease, tuberculosis and other infectious diseases continue to be a public health menace, and

Whereas, immunization programs have not reached their maximum potential and are constantly being improved as, for example, the recent acceptance of the Sabin Polio vaccine, and

Whereas, physical fitness programs in schools and colleges can be effective in improving nutrition, exercise and recreation and by the application of sound health advice reduce the number of accidents occasioned in physical sports, and

Whereas, accident prevention programs on land and water, in home and industry can markedly aid in reducing mortality and morbidity; therefore be it

RESOLVED: That the Presidents Program of the Michigan State Medical Society establish a well-rounded and specific program for the prevention of accidents and disease; said program to recognize the efforts presently being made to suggest means whereby these efforts can be improved, and to act as a coordinating source for public and professional information on this subject, and be it further

RESOLVED: That the following organizations and others of like mind be invited to counsel with the Michigan State Medical Society on this project:

Michigan Cancer Foundation
Michigan Chapter American Cancer Society
Michigan Department of Public Instruction
Michigan Department of Health
Michigan Association of Public Health Officers
Michigan State Police
Michigan Health Council
Michigan Safety Council

Otto K. Engelke, M.D. [Washtenaw]:
Resolution No. 30
Introduced by G. B. Saltonstall, M.D., Delegate at Large
Co-introduced by O. K. Engelke, M.D., Washtenaw County Medical Society
Legislation and Public Relations Committee

XII—30. PRESIDENTS PROGRAM: EARLY DETECTION OF DISEASE

Whereas, early detection of disease provides greatest opportunity for success in the subsequent application of medical knowledge to the end that many lives would be saved and health prolonged, and

Whereas, many new and effective means for early detection and diagnosis of disease are now available such as the "Papanicolau Smear" for malignant and non-malignant disease of the female genital tract; screening programs in schools for the early detection of vision and hearing defects in children; periodic health appraisals based upon time intervals and/or continuous personal health supervision designed to make best use of medical knowledge of the calendar of biologic mishaps for preventative procedures; x-ray tests and skin tests for tuberculosis; routine urinalysis for sugar and blood glucose determination for diabetes, and

Whereas, neither the public nor the profession are making adequate use of the opportunities for early detection and diagnosis of disease; therefore be it

RESOLVED: That the Presidents Program of the Michigan State Medical Society emphasize, encourage and promote:

1. The use in the doctor's office of cytologic diagnosis for the early diagnosis of cancer of the female genital tract and research aimed at extending its use to other anatomic areas.

2. The use in the schools of screening programs for the detection of vision and hearing defects.

3. The use in hospitals and doctors' offices of skin testing and pre-employment and prehospital admission x-ray.

4. The expansion of venereal disease detection facilities.

5. The concept of continuous personal health supervision to make best use of medical knowledge of the calendar biologic mishaps for making physical evaluations of the patient thereby providing an opportunity for early detection as well as the concept of periodic health appraisals.

6. The taking of urinalysis for sugar on all patients and the reporting of new cases.

7. Other means for early detection which are now known or will become known to medical science; and be it further

RESOLVED: That the following organizations, or organizations of like mind, be requested to aid in this effort:

All County Medical Societies
The American Cancer Society
The Michigan Cancer Foundation
The Michigan Tuberculosis Association
Michigan Diabetes Association
Michigan Department of Health
Michigan Health Officers Association
Michigan Public Health Association

John W. Rice, M.D. [Jackson]:
Resolution No. 31
Introduced by G. B. Saltonstall, M.D.
Co-introduced by J. W. Rice, M.D., Jackson County Medical Society
Legislation and Public Relations Committee

XII—31. PRESIDENTS PROGRAM: DISEASE CONTROL

Whereas, there is an ever-increasing need for blood transfusions in the practice of medicine due to more aggressive therapy of malignant and non-malignant diseases, and

Whereas, rheumatic fever is still an active and reportable disease which can be better controlled by continuing prophylaxis, and

Whereas, serious complications of diabetes are much more common in uncontrolled diabetes, and

Whereas, the above are but a few examples of diseases and situations which exist and which can, with present knowledge, be resolved by organized effort, and

Whereas, those committees and agencies who are working upon disease control programs can be aided by the Michigan State Medical Society and its component district and county societies, therefore be it

RESOLVED: That the Presidents Program of the Michigan State Medical Society include the establishment of a disease control program which will recognize the work now being done; will devise means whereby these programs can be improved and new ones begun as needed; and will act as a means of coordinating the separate programs for purposes of continuing professional education and public understanding; and be it further

RESOLVED: That the following organizations, and others of like mind, be invited to work with the Michigan State Medical Society in this effort:

Michigan Diabetic Association
Michigan Association for Crippled Children and Adults
Michigan Cancer Foundation
MSMS Rheumatic Fever Control Committee
American Red Cross
Michigan Organization of Blood Banks
Michigan Tuberculosis Association

Resolution No. 32
Introduced by G. B. Saltonstall, M.D.
Co-introduced by H. B. Zemmer, M.D., Lapeer County Medical Society
Legislation and Public Relations Committee

XII—32. PRESIDENTS PROGRAM: MENTAL HEALTH

Whereas, mental illness and mental health are major factors in adding to the life expectancy of the people as well as increasing the happiness of these people during the additional years, and

Whereas, every doctor of medicine is afforded opportunities to treat mental illness or protect the mental health of his patients in his day-to-day practice, and

Whereas, the psychiatrists have repeatedly expressed their willingness to share their specialized knowledge with their fellow practitioners of medicine as well as with the general public, and

Whereas, every patient needs to be considered as a whole person recognizing his mental and environmental needs as well as those of a physical nature; therefore be it

RESOLVED: That the Presidents Program of the Michigan State Medical Society include therein a project on mental health involving, among other activities, the following:

1. Notice to other MSMS committees of the desire of the Mental Health Committee to be of assistance to them upon request.
2. The establishment of psychiatric units in those general hospitals where adequate psychiatric personnel are available.
3. The involvement of medical schools in home care training for the mentally ill in order to provide adequate instruction of medical students and home aides.
4. The development of plans to improve the non-hospital care of mentally disturbed older persons.
5. A study of the desirability of additional nursing homes qualified to care for mild psychiatric cases and the improvement of same, and be it further

RESOLVED: That the following organizations, and organizations of like mind, be encouraged to participate with MSMS in this program:

Michigan Department of Mental Health
Michigan Mental Health Association
Michigan Psychiatric Association
Wayne State University
University of Michigan
Governor's Commission on Aging
Michigan State Medical Society Mental Health Committee
Michigan Department of Health
Visiting Nurse Association
Nursing Home Association

Claude L. Weston, M.D. [Shiawassee]:
Resolution No. 33
Introduced by G. B. Saltonstall, M.D.
Co-introduced by Claude L. Weston, M.D., Shiawassee County Medical Society
Legislation and Public Relations Committee

XII—33. PRESIDENTS PROGRAM: FULFILLMENT OF PATIENT POTENTIAL

Whereas, there is an increasing number of individuals in a community having chronic disabilities and one reason for this is the prolonging of life due to the advancement in medical science, and

Whereas, this is a continuing situation involving social, economic, psychological, and medical problems for the patient, his family and the community, thereby requiring cooperation from many professions, occupations and businesses and needing the leadership of the medical profession, and

Whereas, early recognition by the doctor of medicine of rehabilitation potentials of the patient, before disability is culminated, can markedly aid in the prevention and minimizing of the effect of the potential disability, and

Whereas, great social, economic and medical gains can be made toward replacing the ignominy of dependency with the dignity of self determination, and ability replace disability, if the patient is followed until he is as close to his potential as possible, and

Whereas, the investment of time by the professions, and money by voluntary and, when necessary, governmental agencies in a program to effectuate greater physical and social independency of the chronically disabled is desirable from social, political and economic standpoints, therefore be it

RESOLVED: That the Presidents Program take cognizance of the responsibilities and opportunity inherent in this situation and encourage, sponsor or promote the following program:

1. The dissemination of knowledge to the medical profession, to related organizations, and to communities of the techniques and philosophies of medically proven policies of rehabilitation, as well as existing facilities for patient rehabilitation and how they can be best utilized.
2. The holding of joint meetings of county medical society and community leaders for the planning of community projects and public presentations to demonstrate the values of and the progress in rehabilitation.
3. The encouragement of undergraduate and post-graduate seminars on rehabilitation methods within, and in connection with, medical and para-medical schools as well as the concept of chronic disability field clinics throughout the state.
4. The endorsment of a survey to define areas of need for the establishment of additional rehabilitation services and the encouragement of the subsequent establishment of such programs, where needed.
5. Cooperation with the Michigan Hospital Association in a program to effectuate the easy transfer of patients from hospitals to medical rehabilitation centers and return, and be it further

RESOLVED: That the Michigan State Medical Society request the assistance, in the furthering of this program, of the following, and like-minded organizations:

Division of Vocational Rehabilitation, Michigan Department of Public Instruction
Michigan Crippled Children Commission
County and State Welfare Departments
Detroit Academy of Orthopedics
Michigan Orthopedic Society
Michigan Academy of Physical Medicine
Michigan Society for Crippled Children and Adults
United Cerebral Palsy Association of Michigan
Rotarians
Health Department
Visiting Nurse Association
Elks
Lions
Michigan Rehabilitation Association
Rehabilitation Institute of Metropolitan Detroit
All Rehabilitation Centers

Lawrence A. Drolett, M.D. [Ingham]:
Resolution No. 34
Introduced by G. B. Saltonstall, M.D.
Co-introduced by L. A. Drolett, M.D., Ingham County Medical Society
Legislation and Public Relations Committee

XII—34. PRESIDENTS PROGRAM: HELP FOR THE AGED

Whereas, the Michigan State Medical Society has for many years concerned itself with problems of the aged, and

Whereas, due to political factors, which have been injected into this problem, it is apparent that medicine must give its utmost in leadership in order to protect the health of the aged from being endangered by policies proposed by those who seek to make political capital of the infirmities of the aged, and

Whereas, the Michigan State Medical Society has spelled out a comprehensive and specific program to help the aged, said program having already succeeded in some respects, therefore be it

RESOLVED: That the Presidents Program of the Michigan State Medical Society include the compiling and development of information related to the aged; advance the MSMS 10-point program of Help for the Aged, and such other additions to the program as may be subsequently determined in this swiftly changing situation, and be it further

RESOLVED: That the following organizations, and others of like mind, be invited to cooperate with the Michigan State Medical Society in this program:

Michigan Health Council
Michigan Association of the Professions
Michigan Gerontology Association
Michigan Commission on Aging
Michigan State Legislature
All County Medical Societies
American Medical Association

Herbert W. Harris, M.D. [Ingham]:
Resolution No. 35
Introduced by G. B. Saltonstall, M.D.
Co-introduced by Herbert W. Harris, M.D., Ingham County Medical Society
Legislation and Public Relations Committee

XII—35. PRESIDENTS PROGRAM: EMERGENCY MEDICAL CARE

Whereas, it has long been a matter of great pride to the medical profession that it has met medical emergencies as they have arisen, and

Whereas, it is apparent that with the complexities of modern civilization, it has become necessary to develop systematized means whereby emergencies of both an individual and communitywide nature can be met, and

Whereas, various areas in Michigan have solved these problems in exemplary manner but knowledge of the many effective ways and means of doing so are not generally known; therefore be it

RESOLVED: That the Presidents Program of the Michigan State Medical Society include the sponsoring of a conference to be charged with the responsibility of developing model plans for the handling of medical emergencies of both an individual and community-wide variety, and be it further

RESOLVED: That the following organizations, and organizations of like mind, be encouraged to participate:

Office of Civil Defense
Michigan Safety Council
Michigan Health Council
Michigan Funeral Directors Association
Michigan State Orthopedic Society
Trauma Committee
American College of Surgeons
Michigan State Police

Edwin H. Fenton, M.D. [Wayne]:
Resolution No. 36
Introduced by G. B. Saltonstall, M.D.
Co-introduced by E. H. Fenton, M.D., Wayne County Medical Society
Legislation and Public Relations Committee

XII—36. PRESIDENTS PROGRAM: MEETING NEED FOR MEDICAL STUDENTS AND INCREASED MEDICAL SCHOOL FACILITIES

Whereas, there is an immediate and pressing need for active recruitment of superior medical students, medical associates and nurses and

Whereas, individual doctors of medicine must do their utmost to encourage young people who have an interest in any of the biological sciences to study medicine, and

Whereas, this can be done through the physician participating in school athletic programs, being active in PTA and other school activities, and taking an interest in young individuals in the late grades and high school, and

Whereas, Future Doctor Clubs have proved eminently successful in guiding scientifically inclined students into medicine and the biologic sciences, and

Whereas, it is reliably estimated that by 1975, 3600 more medical students per year must be graduated in order to maintain the present ratio of physicians to population, which means a 50 per cent increase in medical graduates, and

Whereas, in order to accomplish this, there must be an increase in enrollment within existing schools and from 14 to 20 new schools must be established at a cost of about one billion dollars, and

Whereas, it takes approximately 10 years to put a new medical school in operation plus an additional four years before doctors are produced, it is apparent that this vital matter is one of immediate concern and must be met on a crash basis, and

Whereas, part of the problem of directing superior students into medicine is that established scholarship loan funds are not nearly adequate to meet the competition of the other biological sciences, and existing loan funds provide too little to too few, and

Whereas, the need for scholarship funds is indicated and proven by the 1959 statistics when 52 per cent of the 6799 medical graduates were in debt, the average debt being $4258; therefore be it

RESOLVED: That the Michigan State Medical Society through its Presidents Program develop a specific course of action through its county medical societies and individual physicians to recruit superior medical and paramedical students and initiate a campaign plan for local adoption to increase individual scholarship and loan fund grants, and be it further

RESOLVED: That the Michigan State Medical Society through an educational campaign to M.D.'s and the public, establish an understanding that additional medical school plans must be laid now, and further, that private, state and foundation moneys be obtained so that Federal participation will be held to the minimum necessary to prevent Federal control of education and medicine, and be it further

RESOLVED: That the following organizations, and others of like mind, be requested to cooperate with Michigan State Medical Society in this program:

Wayne State University
University of Michigan
All other universities and colleges of Michigan
Michigan Association of the Professions
Michigan Health Council
Michigan Education Association
Guidance Counsellors Association

R. Wallace Teed, M.D. [Washtenaw]:
Resolution No. 37
Introduced by G. B. Saltonstall, M.D.
Co-introduced by R. W. Teed, M.D., Washtenaw County Medical Society
Legislation and Public Relations Committee

XII—37. PRESIDENTS PROGRAM: EDUCATION

Whereas, every committee of the Michigan State Medical Society has repeatedly emphasized the importance of the expansion of programs which disseminate factual medical and health information to the medical profession and the public, and

Whereas, understanding of medical advancements and scientific programs by the profession and understanding of medical societies' policies and the reasons therefore by the public are vital to the success of the medical profession's aims, and

Whereas, means and media of communications with the profession and with the public exist which are not being used, and those means and media currently in use can be made more effective, therefore be it

RESOLVED: That the Presidents Program of the Michigan State Medical Society explore, and where financially and physically feasible, carry out an expanded program of education to the medical profession giving consideration to the possibilities of:

1. The employment of closed circuit television from medical training centers as a part of a postgraduate medical education program.
2. The establishment of a two-way radio network between the hospitals, medical teaching centers, and the new headquarters of the Michigan State Medical Society to be used for scientific discussion and information as well as the dissemination of medical society news and socio-economic information.
3. The programmed distribution through the Michigan State Medical Society Public Relations Library of brochures, pamphlets and other publications to communicate medicine's messages to all doctors who wish to participate in this program, and be it further

RESOLVED: That consideration be given to the possibilities of increasing the use of public media of communications by:

1. A planned program of TV programs over commercial stations of Michigan.
2. The reinstitution of a weekly medical news program over radio stations in Michigan similar to the highly successful "Tell Me, Doctor" program issued by Michigan State Medical Society in prior years.
3. The holding of a series of meetings, in the various Councilor districts, with newsmen for the purpose of exploring better means for the dissemination of authentic health information, and be it further

RESOLVED: That each project in the Presidents Program be requested to supply prepared materials to the Public Relations Committee of the Michigan State Medical Society for dissemination with recommendations as to the public to which same should be distributed, and be it further

RESOLVED: That the following organizations, and organizations of like mind, be requested to assist in this effort:

County Medical Societies of Michigan State Medical Society
All committees of Michigan State Medical Society
All organizations previously listed in the resolutions, for the Presidents Program

G. B. Saltonstall, M.D. [Delegate at Large]:
Resolution No. 38
Introduced by G. B. Saltonstall, M.D.
Legislation and Public Relations Committee

XII—38. PRESIDENTS PROGRAM: FINANCING HEALTH CARE

Whereas, leadership in determining means for the financing of medical and health care by the individual, the community, the state and the nation is in part the responsibility of the medical profession in view of the demonstrated fact that the participation in payment for medical services is directly related to the success of medical treatment, now therefore be it

RESOLVED: That the Presidents Program of the Michigan State Medical Society in the implementation of its various projects, adhere to the following principles:

Personal medical care is primarily the responsibility of the individual.

When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state and only when all these fail, to the Federal Government. The determination of medical need should be made by a physician, and the determination of eligibility should be made at the local level with local administration and control.

The Speaker: Resolutions 25 through 38 will be referred to the Reference Committee of Legislation and Public Relations.

Harold L. Gordon, M.D. [Midland]:
Resolution No. 39
Introduced by Midland County Medical Society
Hygiene and Public Health Committee

XII—39. VISUAL SCREENING PROGRAM

Whereas, visual screening of preschool and school children when properly done is of value in finding certain ocular defects in those children, and

Whereas, such programs should be carried out by trained persons, but not by a professional person with a vested interest, and

Whereas, it is essential that the public be emphatically informed that screening tests, because of the number of children involved and methods employed, are neither complete nor diagnostic examinations, and

Whereas, standards for visual screening have been studied and established by the Subcommittee of Ophthalmologists of the Child Welfare Committee of the Michigan State Medical Society, therefore be it

RESOLVED: That the Michigan State Medical Society approves preschool and school visual screening if properly conducted, offers the services to its members in helping to plan for such programs, and recommends that no community-wide program in this field be undertaken without the approval of the county medical society or local health department and without using technicians certified by the Michigan Department of Health for Massachusetts Vision Testing Programs or teachers trained by public health nurses for Snellen Screening; and be it further

RESOLVED: That copies of this resolution be sent to all county medical societies, all local health departments, all school superintendents and principals (public, parochial and private), PTA officers, interested service clubs and the Michigan Optometric Association.

The Speaker: This resolution will be referred to the Reference Committee on Hygiene and Public Health.

Ross V. Taylor, M.D. [Jackson]:
Resolution No. 40
Introduced by Jackson County Medical Society
Miscellaneous Business Committee

XII—40. INSURANCE REPORT FORMS

Whereas, use of a single insurance form will increase office efficiency, and

Whereas, the Health Insurance Council has developed a universal form for physicians reports which a majority of insurance companies will accept and which the AMA has approved, therefore be it

RESOLVED: That the MSMS make available the approved Health Insurance Council form for physicians' reports to all members of the MSMS.

THE SPEAKER: This resolution has been referred to the Committee on Miscellaneous Business.

FRANK H. POWER, M.D. [Grand Traverse-Leelanau-Benzie County Medical Society]:
Resolution No. 41
Introduced by Grand Traverse-Leelanau-Benzie County Medical Society
Medical Service and Prepayment Insurance Committee

XII—41. MMS PAYMENT FOR SURGICAL ASSISTANTS

Whereas, since the inception of the Michigan Medical Service M-75 prepayment insurance contracts, there has been a marked difference in the interpretation of those contracts by physicians and subscribers and by the MMS, in regard to the payment of a surgical assistant benefit, with MMS taking the stand that "Technical Assistance is not a benefit when such service is performed in a hospital having a house officer or an approved intern or resident training program;" and

Whereas, "the Basic Principles for Prepayment Medical Care Insurance" as adopted by this House on September 25, 1957, in Section C, "Principles to be embodied in Insurance Contracts," subsection 3-C states: "The following services must be included in any basic program—surgical assistants when required," and

Whereas, the MMS contracts with its subscribers provide under the heading "Service and Benefits, Class II, Surgical assistance by a physician to the physician in charge of the case—at such times as and in such hospitals where and wherein such surgical assistance is not routinely available as a service provided by a hospital intern, resident or house officer," and

Whereas, hospitals approved for intern and resident training, due to hours of duty or insufficient personnel, cannot always routinely provide suitable assistants when required; and

Whereas, this service benefit is paid for by all subscribers to surgical coverage with the MMS, but because of the above circumstances beyond the control of the subscriber, discrimination between subscribers is shown, in that some subscribers receive this benefit and others are deprived of it; and

Whereas, by direction of this House of Delegates, approval of prepayment medical care plans, known as the Seal of Assurance of this Society is to be given by the Medical Care Insurance Committee of The Council only to those plans meeting the requirements of the Basic Principles; therefore be it

RESOLVED: That The Council is hereby directed to take such steps as may be necessary to require Michigan Medical Service to pay for "surgical assistants where required," in accordance with the Basic Principles for Prepaid Medical Care Insurance, as adopted by this House.

THE SPEAKER: The resolution will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

WILLIAM J. FULLER, M.D. [Kent]:
Resolution No. 45
Introduced by Kent County Medical Society
Medical Service and Prepayment Insurance

XII—45. SEPARATION AND DIVESTMENT OF THE MICHIGAN STATE MEDICAL SOCIETY FROM THE MICHIGAN MEDICAL SERVICE

Whereas, the Michigan Medical Service, Blue Shield, was originally developed to provide voluntary prepaid insurance benefits for basic medical and hospital expenses for only indigent and low income individuals, and

Whereas, the Michigan Medical Service, Blue Shield has very successfully established and provided such insurance commonly termed the Doctors' Plan, and

Whereas, the Michigan Medical Service, Blue Shield has expanded, extended, and broadened itself to provide coverage of a much more complex and diverse degree to individuals with incomes far beyond the indigent and low income level, and

Whereas, extension of full coverage of medical benefits and the service principle beyond the indigent and low income groups was not the intent of the Michigan State Medical Society in establishing Michigan Medical Service, Blue Shield, and

Whereas, the Michigan Medical Service, Blue Shield as a result of this extension has incurred financial difficulties, deficits, increased utilization and even abuses not foreseen nor planned for, and

Whereas, these aforementioned problems of Blue Shield are far beyond the original conceptions, scope and understanding of the medical profession and are primarily of an administrative and complicated actuarial nature requiring business and insurance experts to solve, and

Whereas, the medical profession in Michigan and good professional relations are being seriously injured by the public awareness of these problems which are associated by the public with the original conception of the Doctors' Plan and the Michigan State Medical Society's sponsorship of Blue Shield, though these problems are now of an actuarial and administrative nature and are not medical in character, and

Whereas, the Michigan Medical Service, Blue Shield may now well be able to function and administrate for the good of the public and the profession its policies and plans, more efficiently and successfully, unfettered and without direct influence of the Michigan State Medical Society, therefore be it

RESOLVED: That the Michigan State Medical Society through its House of Delegates establish a committee to use every practical means to explore and study the advisability and all ways and means of legally, ethically, financially, responsibly and otherwise separating and divesting itself from the direct sponsorship and responsibility for the Michigan Medical Service while at the same time not jeopardizing the successful future of Blue Shield nor the respect of the medical profession.

THE SPEAKER: This resolution will be referred to the Committee on Medical Service and Prepayment Insurance.

FLOYD B. LEVAGOOD, M.D. [Wayne]:
Resolution No. 46
Introduced by Wayne County Medical Society
Medical Service and Prepayment Insurance

XII—46. PAYMENT FOR MAJOR MEDICAL SERVICES BY MICHIGAN MEDICAL SERVICE

Whereas, Michigan Medical Service reimburses for surgical, obstetrical, and anesthetic services on the basis of specific payments for specific operative and other procedures, and

Whereas, services for major medical care are reimbursed on a per diem basis, and

Whereas, such major medical services ought to be reimbursed in a specific payment for each type of major medical illness; therefore be it

RESOLVED: That in the sense of the House of Delegates, Michigan State Medical Society, that Michigan Medical Service should establish specific fees for services for all major medical services similar to the specific fee schedules in effect for surgical services; and be it further

RESOLVED: That such specific fee schedule for major medical service be employed in all future negotiations between Michigan Medical Service and/or Michigan State Medical Society and governmental agencies for all prepayment insurance plans or contracts wherein medical service is involved.

THE SPEAKER: This resolution will be referred to the Committee on Medical Service and Prepayment Insurance.

FRANCIS P. RHOADES, M.D. [Wayne]:
Resolution No. 42
Introduced by F. P. Rhoades
Resolutions Committee

XII—42. GENERAL PRACTICE RESIDENCIES

Whereas, many general practice residencies are unfilled and many have inadequate progressive and integrated training programs, and

Whereas, the present two-year family practice pilot program of the American Medical Association fails to adequately prepare the young physician to do general practice in his own community, and

Whereas, each segment of organized medicine has, and still determines the minute details and over-all content of their respective training programs, therefore be it

RESOLVED: That The Council on Medical Education and Hospitals of the AMA be directed to formulate other pilot two-year progressive training programs which are acceptable to the American Academy of General Practice, the only national association representing general practice.

THE SPEAKER: This will be referred to the Committee on Resolutions.

D. W. MCLEAN, M.D. [Wayne]:
Resolution No. 47
Introduced by D. W. McLean, M.D., Wayne County

XII—47. POLICY FOR PREPAID MEDICAL CARE INSURANCE PLANS

Whereas, prepaid medical care as embodied in the current M-75 contract of Michigan Medical Service has resulted in a continuous increase in premium costs and has proven financially unsound; and

Whereas, the insurance commissioner of the State of Michigan has directed Michigan Medical Service to develop a sound and workable contract within the next year, and

Whereas, the majority of the membership of the Michigan State Medical Society who reside in the metropolitan areas and service the largest percentage of the contracts is strongly opposed to the principle of service contracts except for the low income group, as contrary to the American ideal of free enterprise and individual liberty; therefore be it

(First Resolve deleted by Reference Committee)

RESOLVED: That it is the opinion of this House of Delegates that Michigan Medical Service should develop a new contract embracing the following basic principles:

1. Uphold the original purpose of Michigan Medical Service to spread the cost of medical care to protect the low income group against the cost of serious illness.
2. Maintain normal patient-physician relationship without the intrusion of any third party.
3. Eliminate all service contracts except for the low income group.
4. Preserve free choice for both the patient and the physician.

And be it further

RESOLVED: That it is the opinion of this House of Delegates that such a contract should:

1. Cover only basic in-hospital medical, surgical, obstetric and anesthesia services.
2. Permit appropriate riders to cover such extra services as x-ray, laboratory tests, office surgery, etc., as options for any purchaser who desires to pay the extra premium.

THE SPEAKER: This resolution will be referred to the Committee on Medical Service and Prepayment Insurance.

MERLE A. HAANES, M.D. [Oakland]:
Resolution No. 48
Introduced by Merle A. Haanes, M.D.

XII—48. FAMILY INCOME—MICHIGAN MEDICAL SERVICE

Whereas, the ultimate success of the concept of service benefits will have to embody the family income principle, and

Whereas, the 1959 House of Delegates expressed a desire that the family income principle be embodied in any new contract, and

Whereas, it was not the intent of this House that the family income principle be subject to the condition of a 15% loading charge, and

Whereas, the membership of the MSMS was not fully cognizant of the implications of the conditions of the present fee structure, and

Whereas, many physicians of the State of Michigan desire the present system of income certification, and

Whereas, the 15% of over income families is significant but not prohibitive, therefore be it

RESOLVED: That the present method of income certification be maintained as is; and be it further

RESOLVED: That the family income principle be made a part of the M-75 contract forthwith or as soon as possible, but without determination by management, and be it further

RESOLVED: That the physician determine the application of the family income principle and when applicable make an additional charge if he so sees fit, and be it further

RESOLVED: That any dispute be handled by an appropriate body empowered to take depositions regarding statements of subscribers.

THE SPEAKER: That resolution will be referred to the Committee on Medical Service and Prepayment Insurance.

MERLE A. HAANES, M.D. [Oakland]:
Resolution No. 49
Introduced by Merle A. Haanes, M.D.

XII—49. LOADING CHARGES MADE ON UNIT VALUES—MICHIGAN MEDICAL SERVICE

Whereas, loading charge of 15% to compensate for single subscriber income has been shown to be inequitable, and

Whereas, the subtraction of 15% in the development of new unit values for a contemplated $6500 contract resulted in a fee schedule less than that in use ten years ago, and

Whereas, this reduction is obviously not in keeping with the economic advances of the past decade, and

Whereas, the present schedule of fees for M-75 at this time are the usual and customary charges for a

large segment of the physicians of the State of Michigan, and

Whereas, any equitable and just fee should be subject to no conditions, and

Whereas, no fee schedule should be upgraded beyond normal economic demands, and

Whereas, the present so-called loading charge of 15% will inevitably create future difficulties, therefore be it

RESOLVED: That the present unit values for M-75 and any future unit values be subject to no conditions or loading factors, and be it further

RESOLVED: That the 15 per cent loading charge be made a permanent part of the unit value of M-75.

THE SPEAKER: This resolution will be referred to the Committee on Medical Service and Prepayment Insurance.

JOHN J. COURY, M.D. [St. Clair]:
Resolution No. 43
Introduced by St. Clair County Medical Society
Resolutions Committee

XII—43. STUDY COMMITTEE RE INDIGENT M.D.'S

Whereas, there exists in this state indigent physicians and physicians' families either due to aging, death or illness. and

Whereas, we are convinced that the existence of the above situation is not the desire of this state medical society, therefore be it

RESOLVED: That this body of delegates form a study committee and that this committee report its recommendations to the next annual session.

THE SPEAKER: That resolution will be referred to the Committee on Resolutions.

J. DUANE MILLER, M.D. [Kent]:
Resolution No. 50
Introduced by J. D. Miller
Kent County Medical Society

XII—50. CIVIL DEFENSE

Whereas, the medical aspects of Civil Defense are essential to the preservation and survival of our population, and

Whereas, the basic unit within the Michigan State Medical Society is the county society, and

Whereas, the AMA is sponsoring an important national conference at which the United States Public Health Service will present its program for Medical Civil Defense, and

Whereas, the information to be presented by the USP HS is vital to the planning of each governmental unit, therefore be it

RESOLVED: That each and every component county society of the MSMS be urged to appoint a Civil Defense Committee Chairman for 1961 and send said chairman to the AMA County Societies Conference on Civil Defense, November 4, 5, 6, 1960.

THE SPEAKER: This resolution will be referred to the National Defense and Disaster Planning Committee.

THOMAS J. DILLON, M.D. [Van Buren]:
Resolution No. 51
Introduced by T. J. Dillon, M.D.
Van Buren County Medical Society

XII—51. TASK FORCE

Whereas, the doctors of medicine of the State of Michigan refuse to accept individual responsibility or cannot accept such because of need for daily care of patients' health, therefore be it

RESOLVED: That the MSMS develop a task force of trained personnel to attend, infiltrate and dominate all indicated public meetings to correct all misconceptions before these meetings publish false recommendations. This task force to be paid by the MSMS to compensate the participants at or near their usual rate of income for such time devoted to such duties.

THE SPEAKER: This resolution will be referred to the Committee on Resolutions.

REPORTS OF COMMITTEES OF THE HOUSE OF DELEGATES

XIV—1. PERMANENT ADVISORY COMMITTEE ON FEES

THE SPEAKER: We do not have any formal report from this committee as they only had one meeting, so we will send the minutes of their one meeting to the Reference Committee on Medical Service and Prepayment Insurance.

XIV—2. COMMITTEE ON COMMITTEES (of House of Delegates)

JOHN G. SLEVIN, M.D. [Wayne]: It should be observed that the House of Delegates has had a Committee on Committees each year since 1957. The House of Delegates apparently has felt that the committee structure of Michigan State Medical Society requires revision because committees have increased in numbers in the past three years from 61 to 89 committees. This is twice as many committees as any other state medical society has.

The cost to the Michigan State Medical Society for committees in 1959 was in round numbers $38,000, and the cost is growing rapidly. The growing number of committees has made the day-to-day work of the Michigan State Medical Society administration very difficult and adds to the over-all cost of operation.

For these reasons, President Darling and several past presidents of our Society have urged that committees be streamlined for greater efficiency and economy of operation.

Now a couple of highlights of the report.

The various committees of the Council now number 41, and the Committee on Committees proposes a reduction to five standing and eight special committees. These are listed on pages 94, 95 and 96 of your handbook.

Regarding the Standing Committees of the Michigan State Medical Society, you will note page 98 of the handbook the recommendations of your Committee on Committees for changes and the first is the change in the name of the Preventive Medicine Committee to Public Health Committee in keeping with the categories of committees which the House of Delegates adopted in 1958.

In addition, the Postgraduate Medical Education Committee now considered a part of the Public Health Committee, we feel, should stand on its own as it has no particular reference to the present Preventive Medicine Committee.

We also recommend the addition of six subcommittees to the Public Health Committee including a reactivation of the Committee on Cancer Control and several existing subcommittees were considered for broadening of their scope of activities. Two special committees of the state society have been recommended as becoming standing committees. These are the Advisory Committee to the Woman's Auxiliary and Advisory Committee to the Michigan State Medical Assistants Society. One new standing committee has been recommended, namely, the Committee on Professional Insurance Plans.

Our Committee on Committees recommended a new section of the bylaws to spell out the right of the Council to appoint special and ad hoc committees. This right is now implied, but should be specified in the bylaws.

The Committee on Committees recommends in their report that the Council utilize existing committees whenever possible before appointing special ad hoc committees, as one method to curtail the mushrooming growth of state society committees.

We find no reason to suggest any changes in the House of Delegates Committees. All of them are ad hoc except for the Permanent Advisory Committee on Fees.

In conclusion, the Committee on Committees desires to acknowledge that without the excellent assistance of the Executive Director who attended all of our meetings and his hard working staff in furnishing this committee with much valuable research material, our task would have been impossible to complete.

THE SPEAKER: This report will be referred to the Committee on Special Committees.

The next report will be from the committee that worked with National Blue Shield this year. This was a combined committee, and they had co-chairmen. Dr. Novy was chairman of our committee and Dr. Stubbs represented National Blue Shield. The report this morning will be given by Dr. Novy and Dr. Stubbs, and Dr. Novy will introduce the board. I would like to have these men come up on the platform so that everybody can see who they are, because this committee has done a tremendous amount of work this year.

XIV—3. HOUSE OF DELEGATES COMMITTEE TO MEET WITH NATIONAL BLUE SHIELD COMMISSION

R. L. NOVY, M.D. [Wayne]: The committee was charged by this House a year ago to bring in a report at this meeting. That report has been sent to you. It has been in your hands since the last part of August. A copy of it is in your handbook (see Page 242).

Doctor Novy introduced Russell B. Carson, M.D., Fort Lauderdale, Florida, Chairman of the Professional Relations Committee of the National Blue Shield organization; Mr. John W. Castellucci, Chicago, Executive Vice President of the National Blue Shield organization; and Donald H. Stubbs, M.D., Washington, D. C., President-Elect of the District of Columbia Medical Society and Chairman of the Board of Directors of the National Blue Shield organization.

XIII. PRESENTATION OF CHAIRMAN NATIONAL BLUE SHIELD PLANS

DONALD H. STUBBS, M.D.: Dr. Novy, Members of the House: I think I have been rather adequately described to you as an octopus, and Dr. Novy mentioned the use of six of my pseudopods or seven. There is just one left that I will employ for a moment in reporting back to you on the actions of this committee as I have seen them.

I want first to thank my friends whom I have seen here in considerable numbers since I came last night for welcoming us from the outside again so warmly after a year of work in this direction. This we are pleased to term our annual pilgrimage to your House of Delegates.

I hope the work is over, and that we have nothing left but the pleasure of a happy future.

I wish to compliment the actions of this committee as Dr. Novy has because they have done a fine job. We found last year when we came to this House of Delegates the good will that I stated at the time would undoubtedly see us through a trying problem. That good will certainly has been present on this committee. I believe that recognition on the part of all of us that this is the essential ingredient to solving problems of this kind will be the first step in our solution, because no specific wording of an agreement can ever take the place of the will to work together.

We will have to see that the efforts to state in principle things that we believe and to which we subscribe is carried out through the efforts of this good will. The dedication of this committee is shared by you, I know, to see that the place of organized medicine in Michigan is squarely behind the good intentions that are described in this report.

I think it is quite fitting that this report should come on the 21st birthday, as it were, of Michigan Medical Service as this Blue Shield Plan comes of age officially under the chronology that has been employed for voting rights in most states, although my State of Georgia now lets them vote at 18, you might remember.

This 21st year is a suitable time to have a program of this sort presented to you, and I might say that it was designed here at home. We from the outside were bystanders in a way. We may have exercised a little catalytic effect, but we did not do the job. It was done here, very much as the man who saw a number of doctors because he was obsessed with the notion that he couldn't sleep, because there was a snake under his bed. Finally, he met one of these doctors on the street and said he was getting along fine now.

He said, "Well, who did it?"

"My brother finally cured it."

"Oh, is your brother a psychiatrist?"

"No, he is a carpenter. He sawed the legs off the bed, and the snake can't get under it any more."

That is what this committee believed it has done for you, and we congratulate them for it.

Since last year when I was here there are several things that have come to pass that we recognize as being obvious and some that have developed that were not quite so obvious to foretell.

The exacerbation in world tensions is something that I know disturbs us all and occupies considerable of our conscious thought, but it is associated perhaps with movements, with ferments and commotion in mankind that has significance to us in this country even at the local level.

Communication and rates of travel have led to a growing sophistication in matters such as we are discussing in this committee. The public knows better what it wants and better how to achieve it even though the achievement may be on political basis that we feel is not well grounded.

Another thing that has happened in this past year is that our public and private debt in this country has increased by some 66 billion dollars while our capital investment has grown less than half that much, about 32 billion.

Now what this means to us here is something very definite, that prepayment is certainly here to stay because we are going farther and farther into the credit business in all of our daily activities as individual citizens of this country, and so we can't get out unless we go through the Government road to compulsory action of some kind, and therefore, we are faced today far more than we were last year with making this matter of prepayment operate in the public interest, so they know it is in their interest and will accept our leadership in doing it in a way that is tolerable to us also.

We have seen continued concern over the ubiquitous problem of aging. This has been one of the outstanding political footballs. It is something that tinges nearly all of the thinking and discussion in matters of this kind. We see along with this sophistication in public and the pressures to do something for the aging, the increasing demands for service types of programs that offer service of a medical type and pay for it on prepayment mechanisms.

We have seen specifically the putting into operation of the Federal Employe Program with its especial challenge of major medical coverage to some five million people, Federal employes, and their dependents in this

country, so that all of these things have added to the responsibility of medicine. They are challenges to all of us in medicine to do the particular job again that I come back to over and over because this is an adjunct to a specific report coming back to you in regard to your efforts to do this thing.

The responsibility of Michigan in the field of prepayment, I believe, is better recognized this year than it was last.

Now as to the report itself, and just a few words, because I as Dr. Novy have no intention of taking your time to read it all. We are quite prepared to discuss it as helpfully as we can in reference committee in greatest detail, but it would be improper to do more at this time than refer to several points.

First, we from the National Blue Shield approve this report without reservation. Secondly, we want to point out that this is a forward-looking, not a backward-looking report. It does not contain elements of recrimination or efforts to place blame for things that may or may not have happened in the past, but to outline a method by which we believe the stage may be set for a bright future. Thirdly, I think that the report itself by implication has clarified the meaning of the term "principles," and we do say flatly that medical societies have not only the right but the obligation to establish and outline the principles upon which they will support prepayment mechanisms.

They have also the right and the obligation to modify these principles or the statement of them if this is needed in the light of developing conditions. Certainly as I indicated in referring to the changes of only one year, conditions do change in this field so that the principles under which we adjust may be slightly modified, but we are pleased with the statement of principles in this report because they are broad enough to give us the leeway to operate, and they are specific enough to indicate clearly the rights of organized medicine in this area.

Fourthly, we believe that this report suggests rather specificially that prepayment and service are the business of medicine. Service is really the personal care of patients by their physicians, and prepayment is designed to help pay for it or to pay for it in full.

You in Michigan have definitely been leaders in this assumption of the contractual obligation to render service under conditions that you state, with fee schedules and income levels that are the prime bases for determining the extent to which service will be given percentagewise.

The report wisely does not attempt to define service in limiting terms, but it does say that you, physicians in Michigan, support the principle of service.

We in National Blue Shield support this as an important principle, and we would urge if need be, that you reiterate your support of it.

Finally, I think that the solution in Michigan will have to be in principle good everywhere. From the standpoint of National Blue Shield this report does conform to this idea, and so we hope that you will see it as we do, that you will agree with the distinguished members of your own Society who have been instrumental in forming it, and that you will assist the national effort in this direction by supporting it yourselves.

R. L. Novy, M.D.: This committee then submits this report as charged by this House to the House. It is in your hands.

Before finally ending this, I feel very much obligated, and I am sure the committee will endorse my statement, that we owe a great deal to the secretary that helped us hour after hour with note-taking, revising, condensing, Miss Kolhede, who sits over there. Miss Kolhede, will you rise, please?

The Speaker: The report of the committee to meet with National Blue Shield Commission is being referred to the Reference Committee on Medical Service and Prepayment Insurance.

XIV—4. HOUSE OF DELEGATES SPECIAL COMMITTEE TO REVIEW MSMS CONSTITUTION AND BYLAWS

H. J. Meier, M.D.: In a sense this report is only an interim report. This committee was charged with the duty of reviewing the Constitution and Bylaws of MSMS and make recommendations concerning any necessary changes to the House of Delegates at the next annual session.

There is a modest report of this in your handbook. It was contemplated that another meeting would have been had of this committee after that modest report was made in the handbook. However, it was found that there were so many resolutions coming from various committees that we could only make an interim report at this time.

The first recommendation that this committee offers concerns MSMS Cancer Control Committee. In the 1959 House of Delegates a resolution was passed that this committee be deleted and the function of the committee be taken over by the MSMS representatives to the Michigan Cancer Coordinating Committee which is a state-wide organization with representatives from various organizations. During the year problems arose which could not be discreetly handled by such an arrangement and The Council in its March 7, 1960, meeting suggested reconstitution of the Michigan Cancer Control Committee and referred the problem to this committee. This committee, after review of the problems, recommends that the phrase "Committee on Cancer Control" be reinserted in Chapter 11, Section 3 of the Bylaws.

A review of the 1959 resolutions from the House of Delegates was then made and action taken as follows:

a) Resolutions Nos. 2, 48 and 49 re: misconduct investigations—no action.

b) Resolution No. 9 re: change in dues delinquency dates—no action.

c) Resolution No. 19 re: deferment of a member's MSMS dues on request of his county medical society. This committee recommends to the House of Delegates that the bylaws be amended as proposed in Resolution No. 19 of the 1959 session by adding a new Section 4 to read:

"Section 4—upon written request of a governing body of a component county society a member shall be granted an extension of time for the payment of dues to the Michigan State Medical Society provided that such extension shall not be beyond the fiscal year of the Michigan State Medical Society."

d) Resolution No. 13 re: Councilors being members of House of Delegates.

This subject was referred to the House of Delegates Special Committee to Study Election of Councilors on Geographic Basis and the Status of Councilors as Voting Members of the House of Delegates which will present their recommendations and then this committee can incorporate it properly in the Constitution and Bylaws.

e) Resolution No. 23 re: transposing the titles of Sections 11 and 12—no action.

f) Resolution No. 25 re: reduced MSMS dues for new members—no action.

g) Resolution No. 29 re: deletion of Grievance Committee, Chapter 7—no action.

h) Resolution No. 32 re: Ethics Committee reports. After discussion of the possible harmful effects of requiring the Ethics Committee to report dismissals of complaints to county societies this committee recommends to the House of Delegates that the word "dismissal" in the last sentence of Chapter 6, Section 7, be deleted.

i) Resolutions Nos. 33 and 34 re: election of the Editor of JMSMS. These resolutions were referred to the House of Delegates and pending outcome of their recommendation this committee will incorporate them in the Constitution and Bylaws in proper sequence for your approval.

j) Resolutions Nos. 44 and 45 re: election of MSMS Secretary and Treasurer by the House of Delegates. These resolutions proposed constitutional changes and were thus laid over one year by the House. Pending the decision of the House, this committee will also incorporate them in proper sequence for your approval.

k) The committee then considered the recommendations of The Council as to changes:

1. Elimination of Cancer Control Committee. This has already been referred to in this report and the committee recommends the re-establishment of this committee.

2. Change the name of MSMS Legislative Committee to Legal Affairs Committee. This was already approved by the House of Delegates—no action.

3. Grant active membership to Armed Forces, Public Health Service, and Veterans Administration physicians which was disapproved by the House of Delegates—no action.

4. Include "death" as reason for refund of MSMS dues which was approved by the House of Delegates—no action.

5. Membership change in the MSMS Ethics Committee which was approved by the House of Delegates—no action.

6. Allow election of four delegates (now three) to the AMA in any one year which was approved by the House of Delegates—no action.

7. Clarify meaning of "meeting" and "session" which was approved by the House of Delegates—no action.

l) Resolution No. 51 re: postgraduate Medical Education Committee membership. Because the Committee on Committees has a recommendation on this problem, there was no action taken.

m) Resolution No. 52 re: voting privileges of Secretary and Treasurer. These were proposed constitutional changes and thus laid over for one year.

If these changes are made the committee will incorporate them in proper sequence for your approval.

n) Resolution No. 53 re: spring session of the House of Delegates—no action, as mechanism for other than annual meeting of House of Delegates is spelled out in Section 4, Chapter 9 of the Bylaws.

To bring the Bylaws into conformity with present procedures followed by The Council in electing its officers and committee chairmen, the following recommendations are made by this committee:

1. Amend Section 1 to read as follows:

Section 1. The Council is the executive Body of the State Society. Subject only to the following, it shall determine the times and places of its meetings. It shall hold an annual meeting in January of each year at which time it shall elect a Secretary, a Treasurer and an Editor of The Journal of the Michigan State Medical Society, each to take office immediately and to serve for a term of one year or until his successor is elected and takes office.

2. Add a new Section 2 to read as follows:

Section 2. The Executive Committee of The Council shall consist of the President, the President-elect, the Speaker of the House of Delegates, the Vice Speaker of the House of Delegates, the Chairman of The Council, the Vice Chairman of The Council, the Secretary, the Treasurer, the Chairman of the Finance Committee, the Chairman of the County Societies Committee and the Chairman of the Publication Committee.

3. Repeal present Section 7.

4. Renumber present Sections 2-6 to conform with the above changes.

The committee realizes that these recommendations may be in conflict with decisions which may be made by the House of Delegates and may have to be revised.

This committee concludes this report with the remarks that because many changes in the Bylaws are being recommended by committees already appointed by the House of Delegates, we believe that further revisions should be deferred until such committee reports are acted upon and then this committee will present for your approval rearrangement, rewording, not to change meaning or content, merely to clarify at the 1961 meeting of the House of Delegates. This will necessitate reappointment of such a committee for next year.

Respectfully submitted,
H. J. Meier, M.D., *Chairman*
L. J. Bailey, M.D.
R. R. Cooper, M.D.
A. B. Gwinn, M.D.
F. P. Rhoades, M.D.
J. A. Witter, M.D.
Lester P. Dodd, LL.B., ex officio

The Vice Speaker: Thank you, Dr. Meier. This report of the Special Committee to Review Constitution and Bylaws will be referred to the Reference Committee on Constitution and Bylaws.

XIV—5. HOUSE OF DELEGATES COMMITTEE TO STUDY PROBLEM OF MALPRACTICE

W. M. LeFevre, M.D. [Muskegon]: I will try to condense this report which is in full in your handbook.

The first section simply dealt with the fact that there are four good insurance companies operating in Michigan on malpractice insurance, and the members are urged, of course, to take advantage of that.

The second section of the report deals with the educational factor which we think is the most important part of the committee's report. It involves talks to the individual county societies outlining conduct on the part of the physician which would help to eliminate malpractice claims.

Now an outline of this talk has been prepared and is supposed to be distributed to you gentlemen in the room right now. But those talks we think are important, and if you don't have anybody in your own county society that cares to do it, if you will contact the committee, we will see that you get someone.

We also feel that these talks should be given to the residents and interns during their teaching program. The committee is ready to do that. We also feel that similar talks, maybe not quite as verbose, should be given to senior medical students to prepare them for their future life.

We feel that that is really the most important part of the whole report. We think also, however, that in certain cases where physicians have been known to inadvertently make remarks which started malpractice action, that they should be quietly talked to and shown the error of their ways. Many times it is done thoughtlessly and not on purpose.

There is one angle to the introduction of malpractice action that we feel we have no way of combatting, and that is the talk between patients about: Well, I had this done. I don't think it is very good. Did you ever have it done? And so on. That kind of stuff starts dissatisfaction, but the only way we can combat that is by following the precepts that are laid down in this talk that we have arranged that apparently is not yet being distributed.

Now we went on a little further than that. We have gathered a rather voluminous amount of material which we are organizing as a library of information on malpractice. That will be kept in my office as long as I am chairman of this committee, and it will be turned over to the chairman of any future committee. We feel that the committee should be kept in existence, although we feel that there is no particular need for any more meetings at the present time. It should simply be kept in existence to fit the problem if it breaks out in a hurry.

The Vice Speaker: Thank you, Dr. LeFevre. This report by the Committee to Study Problem of Malpractice will be referred to the Reference Committee on Resolutions.

XIV—6. HOUSE OF DELEGATES COMMITTEE TO STUDY MICHIGAN STATE MEDICAL SOCIETY PUBLICATIONS

O. J. Johnson, M.D.: Our report is on page 102 in your Handbook. This matter of studying the publications of the Michigan State Medical Society came up for considerable vituperative comments at the last session relative to the election of the Editor. The committee considered this very carefully and have made their recommendations in the report.

We have also recommended certain other changes, and at this session there are resolutions introduced which would establish an editorial board which has already been done by The Council.

I am sure that the Reference Committee will take into consideration the resolution that has been introduced and the action of The Council. I don't care to belabor you with our report, though it is short and the Reference Committee will undoubtedly come back with the proper recommendations.

The Vice Speaker: The report of this committee will be taken into consideration by the Reference Committee on Standing Committees.

XIV—7. HOUSE OF DELEGATES SPECIAL COMMITTEE TO STUDY ELECTION OF COUNCILORS ON GEOGRAPHIC BASIS AND THE STATUS OF COUNCILORS AS VOTING MEMBERS OF THE HOUSE OF DELEGATES

This report will be presented by Dr. D. A. Bowman.

D. A. Bowman, M.D.: This report is printed in the Handbook, page 104.

This had various degrees of impossibility. We were given four basic problems. One of redesignation of the Councilor districts, one of your election, and one working out the recommendation in regard to Councilors acting as delegates, and one regarding the term of Councilor.

The term of Councilor we recommended be changed from five to three years. I am not going to speak about that. It is self-explanatory more or less. As for the Councilors being made delegates at large, we thought that it was very important that we not miss out on the advantage of his experience, his background information. We also meant to point out very plainly that he was to have a voice on the floor, voice and voting privilege. We did point that out in our recommendation.

The election of Councilors poses a very difficult problem and one which we felt was almost impossible to solve. Our recommendation was that the Secretary of the state medical society under the direction of The Council conduct a mail ballot asking for nominations from the members of the district and following this, he would conduct a general mail ballot under the direction of The Council and report the results to the House of Delegates which would certify the results that a majority vote was held and would declare a winner.

This is a very round-about way of doing this, but we felt that it would give better representation from the doctors of the district. It would give it much closer contact and more democratic representation.

The last task was that of redesignation of the Councilor districts. We worked a great deal both in the committee and out of the committee with this problem. We finally came to the conclusion that it was impossible to improve upon this present method of districting the Councilors.

I would like to thank the members of my committee, Dr. Babcock, Dr. Dennis, Dr. Hill, Dr. Lahti and Dr. Stander and the staff of the Michigan State Medical Society.

The Vice Speaker: This report will be referred to the Reference Committee on Constitution and Bylaws.

XIV—8. HOUSE OF DELEGATES COMMITTEE TO REVIEW THE FINANCIAL STRUCTURE OF MSMS

Otto K. Engelke, M.D.: Mr. Speaker, Officers of the Society, Delegates and Distinguished Guests: I have before me the same report that you have before you. This report is found in this booklet that was presented to you when you entered the House of Delegates this year, the large notebook. I would say it is 10 or 15 pages from the front behind the heading "Reports of Special Committees."

This committee was originally authorized by the House of Delegates on September 27, 1955. Its first report was made on September 24, 1956. On September 25, 1956 the House of Delegates ordered the appointment of a similar committee at three-year intervals. This current committee was appointed immediately following the 1959 meeting of the House of Delegates.

Members of the committee are: Otto K. Engelke, M.D., Washtenaw, *Chairman;* A. B. Gwinn, M.D., Allegan; S. E. Chapin, M.D., Wayne; W. B. McIntyre, M.D., Wayne; H. B. Zemmer, M.D., Lapeer.

This committee's studies followed the pattern established by the original House of Delegates Dues and Financial Structure Study Committee of 1955-1956. This report also follows the pattern of the original report covering the same and similar areas of interest with, of course, additional pertinent information on the finances of the "headquarters building" activities of the Society.

The committee members have held four meetings. The Executive Director and the Controller of the Michigan State Medical Society staff were invited to one or more of these meetings as were K. H. Johnson, M.D., President-Elect, and O. B. McGillicuddy, M.D., Chairman of the Michigan State Medical Society Finance Committee.

The officers and staff members of the society gave complete cooperation. Financial reports, budgets, auditor's statements, special Society reports, abstracts of House of Delegates and Council meeting minutes, reports of activities of the other professional societies in the state, as well as dues, etc., of all state medical societies and special research reports were promptly provided the committee.

The meetings were dedicated to a review of the original 1956 committee report, the gathering of basic data, requests for standard and special data, and the hearing of reports of the staff and officers. Portions of the minutes of these meetings and details of items follow. Those present at these meetings were: Dr. Engelke; S. E. Chapin, M.D.; A. B. Gwinn, M.D., and H. B. Zemmer, M.D. Also present at one or more sessions were: K. H. Johnson, M.D., MSMS President-elect; O. B. McGillicuddy, M.D., Chairman of the MSMS Finance Committee; the Executive Director and the Controller of the MSMS Executive Office.

Absent: W. B. McIntyre, M.D.

The committee felt it was pertinent to update the previous report of the committee to Review the Financial Structure of MSMS, as it was presented to the 1956 House of Delegates.

One of the more important items in this report was a listing of central office staff and other personnel. The 1959-1960 personnel roster and their duties are shown.

William J. Burns, Executive Director and Administrator, executes all details of the progressive program devised by the House of Delegates and The Council of the Michigan State Medical Society, as assigned to him by the Secretary (per bylaws, Chapter 11, Section 8).

Hugh W. Brenneman, Public Relations Counsel and Assistant Administrator. Administers the public relations

and central educational program of the Michigan State Medical Society and helps to promote cordial liaison between MSMS and other medical, health, professional, and trade organizations, usually working on the administrative level. Acts as secretary to certain MSMS committees.

Warren F. Tryloff, Assistant to the Executive Director. Assists with administrative details, including numerous outside contracts; aids Executive Director with annual sessions and Michigan Clinical Institutes; also in handling new MSMS building matters with architect, etc.; acts in liaison capacity with certain county medical societies.

Richard N. Philleo, Public Relations Field Secretary. Represents MSMS in legislative activities; assists in other public relations programs; acts in liaison capacity with certain county medical societies.

Robert J. Roney, Controller and Membership Director. Journal advertising; membership records, Directory publications, and correspondence; in charge of building maintenance and supplies; in charge of books of accounts and financial transactions; acts as secretary to certain MSMS committees.

Herbert A. Auer, Secretary to Medical Care Insurance Committee and related committees; assists with production of Journal; advises on layout of Society folders, programs, posters, booklets, etc.

E. Ray Scott, Public Relations Field Secretary in Detroit.

Responsible for public relations activities of the medical profession in Wayne, Macomb, Oakland, Monroe and Genesee counties. Works actively in radio, television and other communications media.

Helen A. Schulte, Administrative Assistant. Chief secretary to Executive Director; supervisor of stenographers' pool; organizes all scientific programs for annual sessions and Michigan Clinical Institutes.

Mary K. Brewbaker, Secretary. Committee secretary, sending notices, agenda, making room reservations, etc.; correspondence and records for technical exhibits at conventions; answers general correspondence.

Jean MacDonald, Secretary to Public Relations Counsel.

Vesta L. Bracy, Assistant Secretary. Helps with bookkeeping and membership records; operates IBM equipment.

Margaret Cornwell, Assistant Secretary. Serves as secretary to Controller and Membership Director, operates IBM equipment.

Vada L. Davis, Assistant Secretary. Serves as secretary to Assistant to Executive Director; Public Relations librarian; supervises distribution of literature, films and other public relations media.

Doris Jarrad, Assistant Secretary. Serves as secretary to Public Relations Field Secretary in Dertoit; works closely with the Michigan State Medical Assistants Society.

Matred Johnson, Assistant Secretary. Transcribes Executive Director's cylinders and Council minutes; takes dictation from Administrative Assistant; proof reads stencils.

Delta M. Berry, member of stenographic pool. Head telephone operator and receptionist; transcribes Executive Director's cylinders; typing and copy work; records all long distance calls.

Jo Ann Hall, member of stenographic pool. In charge of mimeographing; collects and folds all mail twice daily; helps with telephone work; copy work and other typing.

Theresa Knzesicki, member of stenographic pool. In charge of mimeographing and distribution of committee minutes; helps with telephone and reception work; typing and copy work.

Shelby Butts, stenographer. Serves as secretary to MCIC Secretary and to Field Secretary in Charge of Legislation.

Jim Giddings (part-time) mail clerk, equipment operator in processing room.

Al Hazelton (part-time) janitor.

An MSMS Administrative chart was also provided the committee for its use.

[An organization chart is bound with the original of this transcript.]

It was noted that the central staff had grown by one administrative officer and four secretarial employes since the 1955-1956 report. It was felt that the Relative Value Study and other costly items along with an ever-increasing legislative effort, etc. warranted the added employes.

The committee asked for a breakdown of the costs of the Relative Value Study. The committee also asked for a transcript of the House of Delegates action which instructed that a Relative Value Study be conducted. It follows:

Extract from proceedings of the 1957 House of Delegates, page 137 of the January 1958 issue of The Journal, MSMS. Report of Reference Committee on Michigan Medical Service—Reports of The Council:

"D. Basis of Service Benefits.

"1. The Michigan State Medical Society will develop a 'Relative Value Scale' which will assign to the individual surgical, obstetrical and other medical services a value in units proportional to the relative value of that service. The Society will determine the applicable value of one unit for each class of benefit. By multiplying the number of units assigned to a procedure by the value of one unit, the 'dollar allowance' for that procedure is obtained.

"2. (a) The Michigan State Medical Society will establish unit values for medical, surgical and obstetrical procedures and anesthesia for each of the plans.

"(b) For diagnostic laboratory procedures and for all radiologic procedures, the unit value will be the same for all plans.

"(c) For any optional benefits offered by a carrier, the Society will establish appropriate unit values.

"3. Until the Michigan State Medical Society establishes a 'Relative Value Scale,' the scale developed by the California Medical Association shall be used.

"4. No participating physician may charge more for a particular service, rendered a subscriber than the 'dollar allowance' payable for that service under the subscriber's contract. A subscriber covered by Plan C, whose income is designated as in excess of $7500 however, shall be responsible for any part of fees to which he agrees with his physician in excess of the applicable 'dollar allowance.' "

This was passed by the House of Delegates in 1957.

A rough analysis of the costs of this study would seem to remind us that some House of Delegates' actions cost a lot of money and should be very well thought out.

Relative Value Scale Budget for 1959 and 1960—Extract from January 30-31, 1959, Council minutes, page 3, Item d:

"$7500 IBM punching of 300,000 items resulting from proposed survey.

"$500 IBM sorting of these coded items.

"$1500 IBM tabulating results of the survey and coding—a total of $9500.00.

"$2000 printing and mailing 6600 questionaries.

"$3000 committee meetings in 1959.

"$14500—Total for 1959.

"$5000 committee meetings in 1960.

"$2500 printing 7000 copies of final report.

"$22,000 total estimated cost of survey—1959-1960."

Page four of the January 30-31, 1959, Council minutes, Item E, Budgets, includes:

"Motion: That $12000 be added to the Medical Care Insurance Committee Budget for 1959 resulting in a total allocation of $15,000, which includes $12,000 for the Relative Value Scale Subcommittee Project. Carried (two opposed)."

On September 27, 1959, The Council minutes, page 5, Item IX, include the following:

"Dr. Leader reported that in order to conduct the study, an additional appropriation of $12,482.70 would be required if The Council wished to proceed.

"Motion: That the minutes of the Relative Value Study Committee of August 6 including additional appropriations be approved as presented; carried."

This then makes the total for the RVS Study—for two years—$24,482.70.

The 1960 budget for the RVS was established at $19,222.23. (This figure includes unexpended funds previously allocated in 1959.)

An extract from the August 10, 1959, letter of the Market Opinion Research Company of Detroit to Dr. Leader indicates the following:

"We gave you an estimated figure of $10,000 to cover the cost of this project excluding printing and mailing costs. We believe this is a fairly close estimate within our best judgment, however, it is conceivable we may have either over or under estimated our costs. In any event the figure should be within 20% either way."

This was one of the items in the budget approved by the RVS Committee on August 6, 1959, and then approved by The Council on September 27, 1959.

There was some discussion concerning possible creation of a Ways and Means Reference Committee of the House of Delegates to which might be referred suggested items involving major expenditures of funds for special House of Delegates projects, in order that adequate consideration of costs may be secured prior to final House of Delegates action.

A listing of dues of other state medical societies compared to those of MSMS was presented by the MSMS Controller. The chart for 1959 indicated that the highest state society dues is $100 charged by one state society, and the low is $25 charged by six state societies; the average is $48.50. The committee noted that $15 of the current Michigan State Medical Society dues is earmarked for the new headquarters building.

STATE MEDICAL SOCIETY MEMBERSHIP DUES—1959

Alabama	$ 50.00	Nebraska	35.00
Arizona	70.00	Nevada	100.00
Arkansas	30.00	New Hampshire	50.00
California	50.00	New Jersey	30.00
Colorado	60.00	New Mexico	70.00
Connecticut	33.00	New York	25.00
Delaware	50.00	North Carolina	50.00
District of Columbia	50.00	North Dakota	75.00
Florida	40.00	Ohio	25.00
Georgia	40.00	Oklahoma	42.00
Idaho	57.00	Oregon	50.00
Illinois	40.00	Pennsylvania	40.00
Indiana	50.00	Rhode Island	50.00
Iowa	85.00	South Carolina	35.00
Kansas	40.00	South Dakota	25.00
Kentucky	50.00	Tennessee	25.00
Louisiana	50.00	Texas	50.00
Maine	55.00	Utah	75.00
Maryland	50.00	Vermont	45.00
Massachusetts	35.00	Virginia	25.00
Michigan	60.00	Washington	45.00
Minnesota	55.00	West Virginia	25.00
Mississippi	50.00	Wisconsin	75.00
Missouri	35.00	Wyoming	25.00
Montana	53.50		

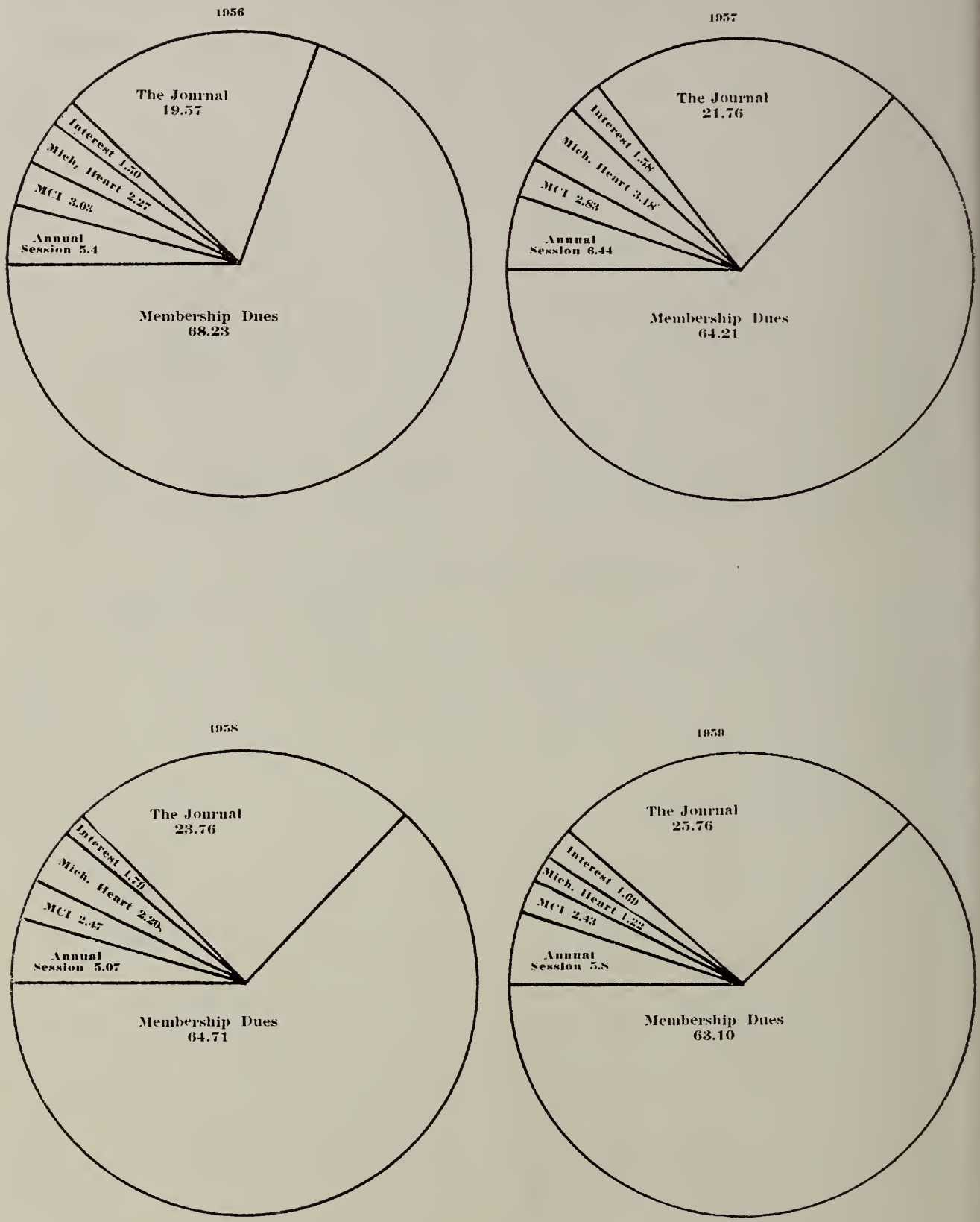
Alaska, Hawaii, Canal Zone, Philippine Islands and Puerto Rico not reported

High	$100.00	(one state has these dues)
Low	25.00	(six states have these dues)
Average	48.58	

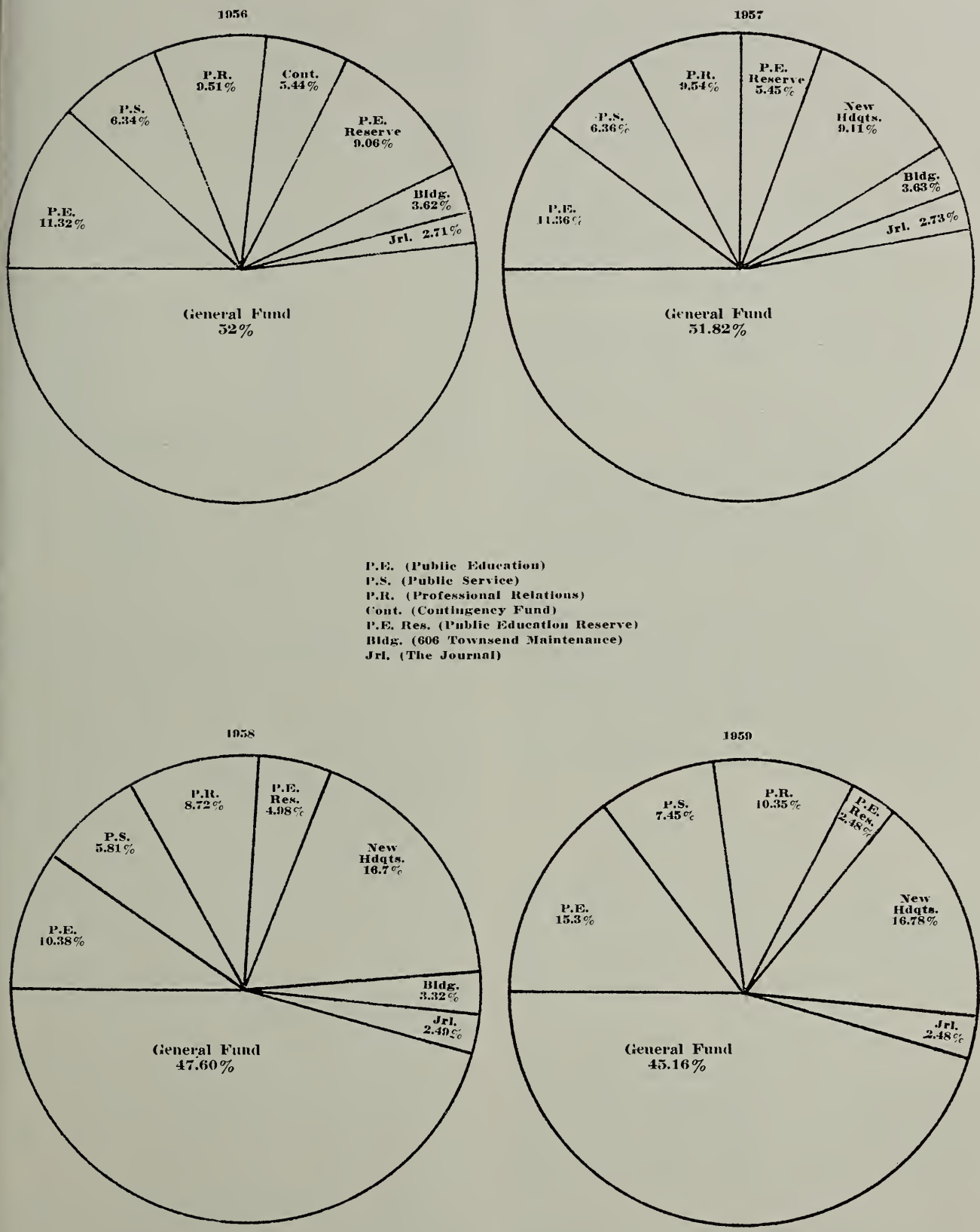
MICHIGAN STATE MEDICAL SOCIETY
Consolidation of 1960 Income and Expense to September 1, 1960

INCOME:		
From: Membership Dues	$376,088.77	
Less: Allocation to New Headquarters	87,060.75	
Allocation to Beaumont Foundation	5,811.71	
Balance from membership dues available for current operations		$283,216.31
Interest and Miscellaneous Income		240.17
Journal—Subscriptions		611.54
Journal—Advertising Sales		90,047.99
Journal—Reprint and Cut Sales		2,571.84
Annual Session		26,182.53
Michigan Clinical Institute		14,215.00
Public Education—Miscellaneous Income		192.75
Prior Years MSMS and AMA Dues		2,118.75
Michigan Heart Association		2,180.67
MSMS Headquarters Contributions		4,725.00
TOTAL 1960 INCOME to September 1, 1960		$426.302.55
EXPENSES:		
General Fund	$155,849.26	
Building Maintenance (606 Townsend)	3,126.88	
The Journal	101,386.83	
Annual Session	5,600.67	
Michigan Clinical Institute	14,040.32	
Public Education Account	36,061.56	
Public Service Account	10,846.62	
Professional Relations Account	25,308.75	
Rheumatic Fever Control Committee	2,976.27	
TOTAL 1960 EXPENSES to September 1, 1960		$355,197.16
GAIN FOR 1960 OPERATIONS of MSMS to September 1, 1960		$71,105.39
Estimated Cost of MSMS Current Operations for Balance of Year to November 30, 1960, based on 1959 actual income and expennse		93,343.79
Estimated Loss December 1, 1960 (not including New Headquarters)		L. $22,238.40
* * * * * * * * * * * * *		
Estimated Additional Payments on New Headquarters Building—1960		$289,628.94
Estimated Cost of Landscaping and Underground Irrigation		12,000.00
Estimated Cost of Furnishing for New Headquarters Building		57,000.00
		$358,628.94
Funds to be Secured from the Sale of Currently Held Bonds		71,566.99
($50,000 in bonds to be retained in General Fund Reserve)		
($35,000 in bonds to be retained in P.E. Reserve)		
Net Funds to be Secured by Borrowing to Complete New Headquarters		$287,061.95
(All of this will not be used in 1960, since by December 1 the building will not be completed and some of the expense will thus be a part of 1961 budget figures)		

SOURCES OF INCOME OF THE MICHIGAN STATE MEDICAL SOCIETY



MICHIGAN STATE MEDICAL SOCIETY DISTRIBUTION OF MEMBERSHIP DUES



P.E. (Public Education)
P.S. (Public Service)
P.R. (Professional Relations)
Cont. (Contingency Fund)
P.E. Res. (Public Education Reserve)
Bldg. (606 Townsend Maintenance)
Jrl. (The Journal)

In 1955, 21 states were below $40, 22 states including Michigan were in the $40-$60 range, and five state societies paid dues ranging from $65 to $100.

The committee noted that in 1959, 21 states were below $50, 22 state societies along with Michigan were in the $50-$70 range, and six state societies paid dues ranging from $75 to $100.

In other words, Michigan stayed in the same bracket of states most of which experienced a dues increase about equivalent to the cost of living rise which has taken place between 1955 and 1959 of about 10-15%. The committee noted that at the time this report is presented to the House of Delegates these latest figures will be outdated.

Osteopath dues are $250 per year, $100 of which is for "education" at state level (1959).

Average monthly expenses of the Michigan State Medical Society are a little difficult to estimate. However, in 1957 they amounted to $35,881 after deducting the amount of American Medical Association membership dues which are an in and out item.

In 1958 they were up to $43,301 (after taking out the AMA). However, this included costs of the land for the new headquarters building of $65,000 or $5200 per month average.

In 1959 they were up to $62,919.88 approximately, less AMA, but including payments on the construction of the new headquarters building.

A good estimate of current costs per month would be approximately $43,000 not including AMA dues and not including payments on the new headquarters building. This figure would include approximately the same 5% increase in costs each year since 1957 and include the normal functions of MSMS such as printing the Journal and operating both the Michigan Clinical Institute and the Annual Session, etc.

The 1960 budget, which includes 1958 and 1959 expenditure figures, was received and carefully reviewed by the committee. Past and current programs were reviewed. Future needs were examined. (See March Journal, Page 469 of the MSMS for published budget.)

Sections of the report of the auditors as of November 30, 1959, were also reviewed. (Also in the March Journal.)

The committee also reviewed the consolidation of 1960 budget estimates of income and expense of the MSMS.

SOURCES OF INCOME
of the
MICHIGAN STATE MEDICAL SOCIETY

	1956	1957	1958	1959
From Membership Dues	68.23%	64.21%	64.17%	63.10%
From Annual Session	5.40%	6.44%	5.07%	5.80%
From Michigan Clinical Institute	3.03%	2.83%	2.47%	2.43%
From Michigan Heart Assn. (Rheumatic Fever)	2.27%	3.18%	2.20%	1.22%
From Interest on Investments	1.50%	1.58%	1.79%	1.69%
From Journal Advertising and Reprint Sales	19.57%	21.76%	23.76%	25.76%

DISTRIBUTION OF MEMBERSHIP DUES

General Fund	52.00%	51.82%	47.60%	45.16%
The Journal	2.71%	2.73%	2.49%	2.48%
Building Maintenance	3.62%	3.63%	3.32%	
Public Education	11.32%	11.36%	10.38%	15.30%
Public Service	6.34%	6.36%	5.81%	7.45%
Professional Relations	9.51%	9.54%	8.72%	10.35%
Contingent Fund	5.44%			
P. E. Reserve	9.06%	5.45%	4.98%	2.48%
New Headquarters Fund		9.11%	16.70%	16.78%

Membership and income figures for the depression and war years were reviewed to determine the effect of hard times and membership depletion in the resources of the Society.

Unpaid members of the Michigan State Medical Society for years 1928-1938.

Year	*Total Members*	*Unpaid Members*
1928	3457	Not available
1929	3463	Not available
1930	3417	250
1931	3235	335
1932	3293	234
1933	3160	450
1934	3393	175
1935	3650	138
1936	3725	141
1937	3963	144
1938	4205	115

Comparison of Membership and Number of Military Members during World War II period. (Military members were granted remission of membership dues.)

1939	4425	–0– Military
1940	4527	-0- Military
1941	4621	209 Military
1942	4714	1127 Military
1943	4786	1142 Military
1944	4702	1151 Military
1945	4686	1353 Military
1946	4799	130 Military
1947	4797	103 Military
1955	6109	430 Military & Associate
1959	6296	45 Military, 352 Associate and 100 delinquent

Population Figures for Michigan

April 1, 1930	4,842,325
April 1, 1940	5,256,106
April 1, 1950	6,371,766
April 1, 1960	7,995,000

It will be noted that unpaid memberships reached a peak of 450 during the depression, less than 20% of members and that military nonpaying members reached an average of about 26% for four years during the last war.

It is conceivable that during another war this figure may be much higher with many doctors pressed into military and civilian defense duties. The committee believes therefore that an effort should be made to maintain reserves even throughout the period of new building construction and cost retirement.

The committee noted that The Council had acted to set aside $100,000 reserves to permit the Society to meet emergencies during this period.

The committee carefully studied Society finances for the future including the immediate future in which a good bit of Society reserves would be used to finance the headquarters building and to continue the "Campaign for Freedom" and "Care for the Aged" educational efforts.

The committee noted that headquarters building costs had risen even beyond the expanded cost estimated for and approved by the delegates in 1958—a standard pattern in current construction. Construction costs always exceed estimates apparently.

The 1959 MSMS House of Delegates approved the Big Look Committee's report (included in the Supplemental Report of The Council) that the new building would cost $602,295 exclusive of land and furnishings.

In this case, it should be noted that the present building size is more realistic in view of the anticipated rapid growth of the state and the medical profession which serves the state.

The 1960 census preliminary figures have confirmed the judgment and foresight of the Big Look Committee and The Council in providing maximum rather than minimum facilities. Too many new buildings are too small the day they are occupied. The 12,000 square feet in the original estimates would have been inadequate.

The committee inspected the building and reviewed the plans for the completion of the headquarters. They concurred in the belief that the 20,000 feet of space provided should be sufficient for the MSMS needs for the foreseeable future unless there were an extraordinary growth of the M.D. population in Michigan.

The committee also concurred in the belief that the headquarters provided a "quality" but no lavish home for a society which should maintain a proper public appearance.

The committee noted that the new State Bar building costs were approximately the same per square foot as those of the new medical society structure and that the latter made a better appearance and was more functional.

A brief outline of Society dues and building allocations for these dues follows:

Years	
1947, 1948, 1949, 1950	$37.00
1951, 1952, 1953, 1954, 1955	45.00
1956, 1957	55.00
1958, 1959	60.00
1960, 1961	65.00

Allocation of membership dues to the new headquarters building fund:

1957	$ 5.00	$ 28,135.00	
1958	10.00	57,238.04	
1959	10.00	59,149.14	
1960	15.00	85,412.52	(to 6-30-60)
1961	15.00		
		$229,934.70	(from bonds in 1959
		140,000.00	the Contingent Fund Bldg. Maintenance Fund and Public Education Reserve)
Total Available 6-30-60		$369,934.70	

The need for the negotiation of all or part of a $300,000 loan at favorable interest rates to maintain the Society and complete the headquarters was noted by the committee.

Dr. McGillicuddy last night, if you will recall, discussed with you the reasons for changing this report somewhat. Since the committee was quoting Dr. McGillicuddy and expressing his philosophy, we could not help but concur in that the loan should be reported by this committee as one to assist in the construction of the building and not the operation of the Society.

Dr. McGillicuddy and the committee discussed the current financial situation of the Michigan State Medical Society and advised the committee members of his philosophy and the need for economy and necessary borrowing in 1960 to complete the new MSMS headquarters building now under construction.

He also pointed to the need of an adequate income from dues to meet building and rising operation costs.

The current financial picture is summarized as follows:

New MSMS Headquarters Building

Total estimated cost of building including landscaping and furnishings	$656,644.00
Cost of land	65,646.00
	$722,292.00
Estimated assessment valuation of building, land and personal property tax on furnishings $234,430 @ tax rate of $55 per M provides estimated annual taxes of at least (minimum)	12,897.50
Estimated interest on loan (1st year)	16,500.00
Estimated taxes (somewhat higher than minimum indicated above)	15,000.00
Estimated maintenance (utilities, janitor service)	15,000.00
	$ 46,500.00
Less present 606 maintenance costs	6,500.00
New expense	$ 40,000.00
Present dues allocation will provide for headquarters	86,250.00
Less: New expense of interest, taxes and maintenance	40,000.00
Available for payment on loan principal	$ 46,250.00

The above figures adjusted as required indicate that the new headquarters fund will be sufficient to completely retire the loan on the building in six years if the present dues allocation of $15 per member is continued.

General Operation

However, the general operations of the Society indicate the following (exclusive of the new headquarters construction and future maintenance):

Estimated income from membership dues based on 5750 members at $65.00	$373,750.00
Allocation of $15 per member to new headquarters fund	86,250.00
Net remaining for operations of MSMS programs	$287,500.00
With depletion of reserves, interest and miscellaneous, income will be very limited. The Annual Session, Michigan Clinical Institute and THE JOURNAL usually provide sufficient funds to pay their own way or one profit will offset any loss in the other; these can be omitted.	
The 1960 budget of all items except the above omissions totals	$316,823.53
An estimated loss in 1960 on General Society operations of	$ 29,323.53

Since most or all of the present reserves will be depleted by the end of 1960, a further increase in membership dues would permit replacement of some of these emergency funds during the same period the new headquarters is being paid for. If $10.00 per member were added this would cover the deficit and leave $28,750 for investment in reserve funds each year. Thus by the time the new headquarters were paid off (in approximately 6 years) the reserves for emergencies would again be built to approximately $145,000. The need for such emergency funds cannot be overemphasized with such programs as the Forand-type legislation and other national and state emergency programs which are trying to change the free private practice of medicine into government-controlled and governmentally operated services.

Salaries of the executive staff of the MSMS and member officers were received. Comparisons were drawn with other societies with activities compared with those of the MSMS. The committee found that our Society was very conservative in its reimbursement of these men. Lower echelon paid staff salaries and benefits were found to be in line with others in similar jobs in Lansing.

Other facets of Society program, operation and financing, too numerous to mention were studied. Delegate activities, alternate delegate activities as well as public

education, public service, professional relations and such programs designed to educate lay people representing all areas in the state were examined and found to be sound.

Conclusions

1. The officers and professional staff of the MSMS are to be commended again for their leadership in a program which is sound and well administered.

a) The AMA Delegates and Alternates as well as members of The Council, committees and others active in the Society make a very valuable contribution to the public and Society welfare at a significant personal sacrifice in most instances.

b) The part-time officer and full-time key professional staff salaries are conservative. Other salaries and benefits are standard for comparable work.

2. The MSMS dues picture over the past few years, while conservative, has permitted the Society to maintain its leadership among other state societies in matters of national and universal interest. This financial support has also permitted the Society to provide excellent state and local education and to provide extraordinary services to the public and to its member physicians.

At the same time, the Society has been able to provide appropriate quarters for its many activities without too much financial strain.

Rising costs cannot be ignored, however, here as elsewhere. A dues increase will be required to continue the orderly progress of the Society. The committee recommends a $10 increase to $75 per year starting at the beginning of 1961. This should permit a continuation of MSMS activities at their present level with the accumulation of reserves to meet unforeseeable emergencies and should permit paying off the loan on the building in about six years. The committee recommends a dues increase rather than an assessment because dues are income tax deductible.

3. The committee recommends the study of the establishment of a "ways and means" type of reference committee of the House of Delegates to appraise the costs of new or special House of Delegates projects before they are voted by the House.

4. The committee recommends that another Finance Study Committee of the House be established in five years to function as have the committees of 1956 and 1960.

The Vice Speaker: Thank you, Dr. Engelke, for this study, the meticulous report on the financial structure of the Michigan State Medical Society. This report will be referred to the Reference Committee on Special Committees.

XV. REPORTS OF MSMS STANDING COMMITTEES

The Committee on Postgraduate Medical Education, and the report on Preventive Medicine Committee with its subcommittees; namely (1) Committee on Rheumatic Fever Control; Maternal Health Committee (and subcommittees); the Venereal Disease Control Committee.

Occupational Medicine Committee; Tuberculosis Control Committee; Mental Health Committee; Child Welfare Committee (and subcommittees); Iodized Salt Committee; Geriatrics Committee, and Committee on Diabetes.

The Public Relations Committee (and subcommittees). The report of the Ethics Committee. The Legal Affairs Committee.

These reports of Standing Committees will be referred to the Reference Committee on Standing Committees.

XVI. REPORTS OF MSMS SPECIAL COMMITTEES

The Special Committees are (1) Scientific Radio Committee; the Advisory Committee to Woman's Auxiliary; the Advisory Committee to Michigan State Medical Assistants Society and the Study Committee on Prevention of Highway Accidents.

There are no reports available on the Mediation Committee or Special Committee to Meet with Michigan Funeral Directors Association—all referred to Reference Committee on Special Committees.

The Speaker: Dr. Findlayson will be acting chairman of the Committee on National Defense and Disaster Planning.

R. Wallace Teed, M.D.: Mr. Chairman, I believe it is obvious to all of us here that a tremendous amount of work has gone into the reports made not only by the Council, but by the various committees this morning. As a result, we are better able to carry on our work.

I would move a vote of appreciation and commendation to these committees.

[*The motion was duly seconded.*]

The Speaker:

All those in favor say "aye"; opposed "no".

[*Carried.*]

[The meeting recessed at 12:50 o'clock.]

MONDAY EVENING SESSION

September 26, 1960

The third meeting of the House of Delegates reconvened at 8 o'clock with J. J. Lightbody, M.D., The Speaker, presiding.

Clifford W. Colwell, M.D. [Genesee]:
Resolution No. 53
Introduced by Genesee County Medical Society
Resolution Committee

XII—53. RESIDENCY TRAINING PROGRAMS

Whereas, The Council on Medical Education of the AMA has decided that an increasing emphasis in the future will be placed on outpatient clinic teaching for residency training programs, including general practice residencies, and

Whereas, today's private hospital does not have any significant indigent patient case load to justify outpatient clinics on a recurring patient basis, and

Whereas, the private hospital has much to offer the general practice resident and in fact, does a large part of the training of general practitioners, and

Whereas, organized medicine does not sanction nor want to encourage hospitals to engage in the private practice of medicine through outpatient clinics, and

Whereas, it is not feasible, nor should it be demanded that private staff physicians establish office practice in hospitals for training purposes, therefore be it

RESOLVED: That our delegates to the AMA House of Delegates be instructed to present to the AMA House of Delegates a resolution establishing the policy that the extent of ambulatory patient care in general practice residencies be determined by local conditions and that outpatient clinics in private hospitals not be a condition for approval of a general practice residency program.

The Speaker: This resolution will be referred to the Reference Committee on Resolutions.

Louis F. Hayes, M.D. [North Central]:
Resolution No. 54
Introduced by North Central Counties Medical Society
Committee on Rules and Order of Business

XII—54. REVISED RULES AND ORDER OF BUSINESS OF HOUSE OF DELEGATES

Whereas, the majority of discussion, expression of opinion and the bulk of work accomplished is in the

meetings of the Reference Committees of the House of Delegates, and

Whereas, under the present order of business, insufficient time is alloted to meetings of reference committees, and

Whereas, the number of items of business to be considered by the House are increasing, and

Whereas, the problems considered are becoming increasingly more complex, requiring that more time be spent in discussion, therefore be it

RESOLVED: That the annual meetings of the MSMS House of Delegates consist of six meetings with the following Order of Business:

Sunday Afternoon

1. Call to Order by Speaker
2. Report of Committee on Credentials
3. Roll Call
4. Prayer
5. Appointment of Reference Committees
6. Speaker's Remarks
7. President's Remarks
8. President-elect Remarks
9. Annual and Supplemental Reports of The Council
10. Report of Delegates to American Medical Association
11. Brief of Annual Report of Woman's Auxiliary
12. Brief of Annual Report of Michigan State Medical Assistants Society
13. Report of Michigan Medical Service
14. Awards

Sunday Evening

15. Reports of House Committees
16. Reports of Standing Committees of MSMS and Special Committees of MSMS
17. Introduction of Resolutions

Monday A.M.

Monday P.M.

Tuesday A.M.

18. Introduction of Resolutions
19. Reports of Reference Committees

Tuesday P.M.

20. Final Report of Reference Committees
21. Elections

and be it further

RESOLVED: That to save time and implement the work of the delegates, that

A. The present printed handbook be discontinued

B. That all preliminary reports of

1. The Council and Council Committees
2. Delegates to the AMA
3. Michigan Medical Service
4. House Committees
5. MSMS Committees

now included in the printed handbook be discontinued.

C. That all of the above reports be complete and included in the loose-leaf notebook introduced at this session; such reports being completed as of the 31st of August, and

D. The above notebooks with complete reports be sent to delegates by the 20th of September, and

E. The present loose-leaf notebook include other miscellaneous information (such as the Constitution, Committee Membership, etc.) now included in the printed handbook, and

F. That all reports of the above Committees be accepted by the delegates in the printed form with only explanatory remarks being made by the chairmen from the podium.

THE SPEAKER: This resolution is referred to the Reference Committee on Rules and Order of Business which will be made up of Dr. Weston as chairman, Dr. Brown, Dr. Wenzel and Dr. Oakes.

EDWIN H. FENTON, M.D. [Wayne]:

Resolution No. 55
Introduced by Wayne County Medical Society
Legislation and Public Relations Committee

XII—55. THE PEOPLE-TO-PEOPLE HEALTH FOUNDATION

Whereas, the People-to-People Health Foundation (and its Project Hope) has been established to bring the skills and techniques developed by the American Medical and allied professions to other nations of the free world in their own environment, adapted specifically to their needs and their ways of life; and

Whereas, the Foundation depends on the support of the American people led by doctors of medicine, the allied professions, business and industry; and

Whereas, many doctors of medicine, local, state and national medical organizations have endorsed the Foundation's program; and

Whereas, a number of members of the Michigan State Medical Society have volunteered to serve on a representative committee of doctors of medicine in our state; therefore be it

RESOLVED: That the Michigan State Medical Society endorses and commends the interests and objectives of the People-to-People Health Foundation and the work of the Michigan Physicians Committee for the People-to-People Health Foundation.

THE SPEAKER: This resolution will be referred to the Reference Committee on Legislation and Public Relations.

ROSS V. TAYLOR, M.D. [Jackson]:

Resolution No. 52
Introduced by Jackson County Medical Society
Legislation and Public Relations

XII—52. MICHIGAN CRIPPLED CHILDREN COMMISSION FEE SCHEDULE

Whereas, the fee schedule of the Crippled Children's Commission is wholly unrealistic and inadequate in comparison to any other governmental fee schedule including all welfare fees—and

Whereas, many physicians have a significant part of their practice devoted to the care of crippled and afflicted children, and

Whereas, we as doctors of medicine desire the highest quality of medical care for our crippled and afflicted children, therefore be it

RESOLVED: That the Legislature of the State of Michigan be requested to adjust the Michigan Crippled Children Commission fee schedule for doctors of medicine to conform to the Michigan Uniform Fee Schedule for Government Welfare Agencies.

THE SPEAKER: This resolution has been referred to the Reference Committee on Legislation and Public Relations.

* * *

I would like the House to give a formal welcome to the two deans of our medical schools who are now present, Dean Hubbard of the University of Michigan and Dean Gordon Scott of Wayne State. *(Applause)*

We are very happy to have both of you here. Feel free to roam through all the committee meetings and sessions of the House.

XVII. REPORTS OF REFERENCE COMMITTEES

XVII—1. REFERENCE COMMITTEE ON REPORTS OF THE COUNCIL

James B. Blodgett, M.D. [Wayne]:

XVII—1a. ANNUAL REPORTS OF THE COUNCIL

The committee considered the Annual Report of The Council 1959-1960 as published in the Handbook for Delegates and the Supplemental Report of The Council as presented to the House by the Chairman, Dr. Meier.

The committee commends the members of The Council for the large amount of work they have accomplished this year and notes that the monthly meetings of The Council were attended by the entire Council rather than an Executive Committee of The Council.

The Committee notes the continuing high level of scientific endeavors in the high quality of the scientific sections of the annual meeting in September and in the Michigan Clinical institute.

The Committee took no action on the financial reports of The Council, since these are covered by the House of Delegates Committee to review the Financial Structure of MSMS.

The committee notes the change in format in The Journal and the continued high quality of its scientific articles. We were favorably impressed by the stimulating effect of the issue devoted to a single county society.

The committee expresses its full approval of the splendid scope of the President's Program.

The improved communications between the Councilors and delegates for better integrated activity of the MSMS is commended.

We note with pride the fact that Michigan's Mrs. W. G. Mackersie was installed as president of the Woman's Auxiliary to the American Medical Association last June.

We approve the action of The Council in continuing the annual awards dinner, which was held in Detroit in January.

The MSMS Workshop on Aging held at the Kellogg Center, East Lansing on April 3, developed ten recommendations which are heartily endorsed by The Council and approved for implementation by The Council and this committee as follows:

(a) Removal of compulsory retirement by industry and labor through voluntary and legislative action.

(b) Encourage and work for program to provide work opportunities for the aged.

(c) Encouragement of state and community governments to share the purchase cost of voluntary health insurance for those over 65 who need financial assistance.

(d) Participation by the medical profession in the preliminary meetings on local and state levels prior to the 1961 White House Conference on Aging.

(e) Encourage increasing cash benefits to those receiving Old Age Assistance.

(f) Exploring the possibility of including under OAA the "marginally indigent" person who is dependent except for unusual trouble; and considering OAA as a possible mechanism for sharing of the premium cost of voluntary health insurance.

(g) Possible establishment of a privately financed plan comparable to the Federal Deposit Insurance Corporation (which guarantees bank depositors against loss) which would guarantee health insurance premium payments, in whole or in part as need dictates, for those over 65 who are unable to keep up such payments.

(h) Encourage pilot program for the construction of model housing units for the aged near a medical school so that scientific study could be given to the needs of the aged by faculty members. This could be done by private enterprise under present liberalized mortgage laws for this type of construction.

(i) Encourage an educational program calling for preretirement planning beginning at age 45.

(j) Place emphasis on a preventive medicine program to include periodic health appraisals; gathering of health data, control of communicable disease, improving patient care and rehabilitation in nursing homes through licensure, and the developing of chronic disease hospital units.

Mr. Speaker, I move the adoption of this portion of the report; the motion was seconded.

The Speaker: It has been moved and seconded that this portion of the report be adopted.

J. Duane Miller, M.D.: I would like to amend the motion that this report be adopted with the omission of Section H.

William J. Yott, M.D.: I second the motion.

The amendment was put and lost.

The main motion was put and carried.

James B. Blodgett, M.D.: The committee approves the recommendation of The Council that a short general meeting of the Society be held to install new officers and for other pertinent business. The time of this meeting should be at the discretion of The Council.

Mr. Speaker, I move the adoption of this portion of the report. [*The motion was duly seconded and carried.*]

James B. Blodgett, M.D.: In the Handbook under Governmental Agencies the committee notes that a new printed revision of the Uniform Fee Schedule for Governmental Welfare Agencies was developed by the House of Delegates Permanent Advisory Committee on Fees and was distributed to all Governmental Agencies and personnel in December 1959. The committee is informed that this fee schedule closely parallels that of Plan A of the current Michigan Medical Service M-75 contract. The committee draws attention to the fact that these fees are substandard and not to be construed as representing proper fees for non-welfare agencies or services.

Mr. Speaker, I move the adoption of this part of the report. [*The motion was duly seconded and carried.*]

James B. Blodgett, M.D.: The reports of the thirteen committees of the Council were reviewed for information and are recommended to the delegates. The committee wishes to express its appreciation to the many members of these committees who have done so much to carry forward the work of the Michigan State Medical Society.

The committee notes with approval progress that is being made in the completion of the new headquarters building. The members of the Big Look Committee are highly commended for their continuing efforts toward the completion of this project. In the supplemental annual report of the Big Look Committee approval is requested for the expenditure of $64,144.00 for the purpose of furnishing the building. This money has already been budgeted in the projected costs of the building in the Big Look report and the report of the House of Delegates Committee to review the financial structure of the MSMS. The committee approves this expenditure.

Mr. Speaker, I move the adoption of this portion of the report. [*The motion was duly seconded and carried.*]

James B. Blodgett, M.D.: The committee commends the work of the Public Relations Department in spite of the sometimes limited funds provided by The Council in the interest of economy.

Delegates are referred to the Handbook under "Matters Referred for Action by the 1959 House of Delegates." The committee reviewed all these actions and reports that the action taken by the Council was in conformity with both the letter and spirit of the resolutions referred to The Council.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

James B. Blodgett, M.D.: Mr. Speaker, in the supplemental report of The Council, it is noted that The Council recommends that an early number of The Jour-

NAL of the MSMS be dedicated to Dr. Haughey in recognition of his long and valuable service to MSMS. In this action your committee heartily concurs. The committee moves a standing vote of its recognition of Dr. Haughey's splendid service to the Michigan State Medical Society.

[*The motion was supported and carried by a rising vote.*]

JAMES B. BLODGETT, M.D.: With respect to the Campaign for Freedom the committee commends the Council and officers of the Society for their influence in defeating the Forand-type of legislation.

The Council offers fourteen recommendations for action by this House. The committee approves these recommendations as follows:

1. That the House of Delegates give approval to the President's Program and urge enthusiastic support of this important project by all members.

2. That the Council be authorized to arrange Councilor conferences prior to the annual session, to continue communication and share information with delegates, alternate delegates and component society officers, as during the past three years.

3. That the House of Delegates give fitting recognition to the first Michigan lady to become President of the Woman's Auxiliary to the American Medical Association—Mrs. W. G. Mackersie.

4. That the House of Delegates approve the holding of an annual "General Meeting" of the State Society.

5. That component societies be encouraged to sponsor "County-State Society Nights" once per annum, to augment communication and information on matters vital to the full membership of all county societies in Michigan.

6. That the House of Delegates approve amendment to the Bylaws (Chapter 10, Section 1) to confirm the traditional practice of electing the officers of The Council in September, immediately after the election of new Councilors by the House of Delegates.

7. That the House of Delegates reactivate the MSMS Cancer Control Committee by approving amendment to Bylaws (Chapter 11, Section 3) as the guidance and advice to this committee is necessary at this time.

CLARENCE I. OWEN, M.D.: I move this Seventh recommendation be removed from this report until we get the Reference Committee report on the report of the Committee on Committees. [*The motion was duly seconded and carried.*]

JAMES B. BLODGETT, M.D.: Recommendation 8, that The Council be authorized to send MSMS representatives to Washington, D. C., in 1961 on the occasion of the Annual Michigan Day, as recommended for many years by the House of Delegates.

9. That the House of Delegates endorse the action of The Council in developing and implementing an intensified crash program against political medicine for the aged; further, that the House of Delegates urge every MSMS member to recognize the seriousness of this threat and personally to inform his patients and other friends now of the fallacies and dangers of this ill-advised program which will dilute the present high quality of medical care for all people.

10. That the House of Delegates favorably consider a resolution establishing a system of awards for the employed personnel of the Michigan State Medical Society based upon length of time in satisfactory service and providing proper recognition in the form of insignia and other emoluments.

I would like to move that Sections 6 and 10 be deleted until other committees studying these matters bring in their reports.

[*The motion was supported, discussed and carried.*]

JAMES B. BLODGETT, M.D.: I think the rest of these recommendations are new recommendations and have not been covered by other resolutions.

11. MSMS invite other participants in the Michigan White House Conference on Aging to join with it in issuing a dissenting report on the Conference, which is to be transmitted to the national conference in Washington in January, 1961.

THE SPEAKER: It has been moved by Louis F. Hayes, M.D. [No. Central] and seconded that we discuss the remaining recommendations of The Council and the supplementary report of The Council as individual recommendations. The motion was put and carried.

Recommendation No. 1

CLARENCE I. OWEN, M.D.: I move that in view of discussion, we delete Item No. 1.

THE SPEAKER: The motion was made by Dr. Owen and seconded by Dr. Hayes to remove Item No. 1 from the recommendations.

All those in favor say "aye"; opposed "no". The motion was discussed and carried.

Recommendation No. 2 was reread by Dr. Blodgett who moved its adoption.

[*The motion was duly seconded and carried.*]

Recommendation No. 3 was reread by Dr. Blodgett who moved its adoption.

[*The motion was supported and carried.*]

Recommendation No. 4 was reread by Dr. Blodgett who moved its adoption.

[*The motion was duly seconded and carried.*]

Recommendation No. 5 was reread by Dr. Blodgett who moved its adoption.

[*The motion was duly seconded and carried.*]

JAMES B. BLODGETT, M.D.: Mr. Speaker, No. 6 and No. 7 have already been taken care of.

Recommendation No. 8 was reread by Dr. Blodgett who moved its adoption.

[*The motion was duly seconded and carried.*]

Recommendation No. 9 was reread by Dr. Blodgett who moved its adoption.

[*The motion was duly seconded, discussed and carried.*]

JAMES B. BLODGETT, M.D.: Recommendation No. 10 is for awards for personnel and has been temporarily bypassed.

Recommendation No. 11 was reread by Dr. Blodgett who moved its adoption.

[*The motion was duly seconded and carried.*]

Recommendation No. 12 was read by Dr. Blodgett: That MSMS express to the Michigan Legislature its concurrence in the two measures approved by that body on September 23, 1960, which provide health benefits for our needy aged citizens. MSMS also should extend to the Legislature and other state departments and agencies affected by this new legislation its fullest cooperation in implementing the new program and assessing the results.

Mr. Speaker, I move the approval of this recommendation.

[*The motion was duly seconded and carried.*]

Recommendation No. 13

JAMES B. BLODGETT, M.D.: MSMS develop and carry out an alive, alert and dynamic program of civic participation in all proper political and legislative spheres to insure continuation of the principles it believes to be in the best interests of the American public. I move the adoption of this recommendation.

[*The motion was duly seconded and carried.*]

Recommendation No. 14

JAMES B. BLODGETT, M.D.: MSMS periodically consider allocation of sufficient funds and provisions of adequate staff personnel as they become necessary for the successful pursuit of the above purposes.

Mr. Speaker, I move the approval of this recommendation.

[*The motion was duly seconded, discussed, and lost.*]

JAMES B. BLODGETT, M.D.: Mr. Speaker I move the adoption of this report in its entirety with the exception of those portions which have been deleted or amended.

[*The motion was supported and carried.*]

THE VICE SPEAKER: Thank you, Dr. Blodgett, for this fine report.

XVII—2. REFERENCE COMMITTEE REPORT ON OFFICERS' REPORTS

Gaylord S. Bates, M.D. [Wayne]: The committee met on Monday afternoon, September 26. Referred to this committee were the Speaker's remarks, the President's remarks, the President-elect's remarks, the Report of the Delegates to the American Medical Association, the brief of the Annual Report of the Woman's Auxiliary, and the brief of the Annual Report of the Michigan State Medical Assistants Society.

XVII—2a. SPEAKER'S REMARKS

The committee compliments the Speaker for his explanations and suggestions designed to promote the orderly conduct of business in this House. The introduction of the loose-leaf Reference Notebook is worthy of mention, praise and perpetuation.

Mr. Speaker, I move the adoption of this part of this report.

[*The motion was duly seconded and carried.*]

XVII—2b. PRESIDENT'S REMARKS

Gaylord S. Bates, M.D.: The remarks of our retiring President, Mr. Darling, reflected to your committee a devoted, loyal, thoughtful servant of this Society. We note his particular concern with the cause of medical education and the recruitment of promising young people to the profession of medicine. We believe this is of grave importance and should become an item of active interest to this Society. Sponsorship of Teen-age M.D. Clubs, as he suggested, could well become a useful device.

The comments upon finances of the Society and the re-creation of the Cancer Control Committee meet with approval.

Mr. Speaker, I move the adoption of this part of this report.

[*The motion was duly seconded and carried.*]

XVII—2c. PRESIDENT-ELECT'S REMARKS

Gaylord S. Bates, M.D.: Regarding the President-elect's remarks, the burden was a call for unity in devotion to the basic interests of the medical profession, namely, the health and welfare of the public it serves. On a note of optimism the President-elect projected the new Society headquarters building as a focal point about which to mobilize, and from which to lead, all capable forces upon an ambitious five-year, state-wide health improvement program.

Your committee approves the concept of the so-called "President's Program" as a vehicle for uniting the profession to serve more effectively in promoting the health and welfare of the public. However, we have misgivings about the use of the five-year term, the promise of increased life expectancy and the MSMS centennial year, as devices to promote the program, lest the public relations aspect becames dominant.

We suggest that the tenor of the remarks of the President-elect augur well for the Society for the coming year.

Mr. Speaker, I move the adoption of this portion of this report.

[*The motion was supported and carried.*]

XVII—2d. DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Gaylord S. Bates, M.D.: In the report of the Delegates to the American Medical Association there were no items of sufficient moment to draw comment from your committee. We can only thank the delegates for the informative report and the evidence of their active participation in the affairs of the parent association.

Mr. Speaker: I move the adoption of this portion of this report.

[*The motion was supported and carried.*]

XVII—2e. PRESIDENT OF WOMAN'S AUXILIARY

Gaylord L. Bates, M.D.: The brief of the Annual Report of the Woman's Auxiliary serves its most useful purpose in bringing to the attention of this Society the varied activities which complement and enhance our own endeavors. Of particular importance is the program of scholarships and loan funds to aid in the recruitment of nurses and other personnel allied to the field of medicine.

Worthy of praise and thanks is the important though less tangible effort in the legislative field.

We compliment the Auxiliary and share their pride in the selection of one of their members, Mrs. Kathleen Mackersie, to be national president. Your committee extends congratulations for a fine year of accomplishment, and appreciation for the loyal support of the Auxiliary.

Mr. Speaker, I move the adoption of this portion of this report.

[*The motion was duly seconded and carried.*]

XVII—2f. PRESIDENT OF MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

Gaylord S. Bates, M.D.: The brief of the Annual Report of the Michigan State Medical Assistants Society is an excellent one and merits approval. We cite for commendation a growth in membership, an increase in the number of component societies, and the operation of an In-Service Training Pilot Study. It is noted that there has been some difficulty in meeting quotas of students per class in certain pilot study areas. This project merits the support and encouragement of the Society.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

Gaylord S. Bates, M.D.: Mr. Speaker, I move the adoption of the entire report.

[*The motion was supported and carried.*]

The Vice Speaker: Dr. Bates, we say thanks for your prompt report.

Orchids to President Mrs. Kathleen Mackersie

Louis F. Hayes, M.D.: Mr. Speaker, I would like to make a comment and a motion regarding these last two committee reports. We have, as the House of Delegates, approved an action, a recommendation of The Council. We have also approved the officers' report wherein it was stated that fitting recognition should be given to Mrs. Mackersie for her election as President of the Woman's Auxiliary of the American Medical Association, but there has yet been no formal motion to make a fitting recognition, so I would like to move that this House unanimously extend by written letter, if she is not able to be present, our congratulations and our pride in her election and accompany that with—which is dear to all females—some kind of flowers.

[*The motion was supported and carried.*]

XVII—3. REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

John G. Slevin, M.D.: The Reference Committee met on the afternoon of September 26, 1960.

XVII—3a. HOUSE OF DELEGATES COMMITTEE TO STUDY MSMS PUBLICATIONS

This annual report was approved with the exception of the section regarding the selection of the editor. It

is recommended that there be no change in the present method of appointment of the editor of The Journal Michigan State Medical Society.

It is noted that The Council has established the Publications Committee of The Council as the Editorial Board, which assumes, with the Editor, responsibility for The Journal. Attention is invited to the fact that the Committee on Committees made a similar recommendation concerning the Editorial Board and advised that Chapter 10, new Section 2 (c), be added to the Bylaws. Your Reference Committee recommends the adoption of this change in the Bylaws.

Mr. Speaker, I move the adoption of this portion of the report.

The Vice Speaker: Do I hear support?

[*The motion was duly supported and carried.*]

XVII—3b. POSTGRADUATE MEDICAL EDUCATION COMMITTEE

Approval of the report is recommended. Your Reference Committee considers that the work of the Postgraduate Medical Education Committee deserves commendation. It should be noted that the committee is prepared to give postgraduate educational courses especially in the smaller communities whenever requested.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

XVII—3c. PREVENTIVE MEDICINE COMMITTEE

Approval of the report is recommended.

Mr. Speaker, I move the adoption of this portion of this report.

[*The motion was supported and carried.*]

XVII—3d. RHEUMATIC FEVER CONTROL COMMITTEE

It was noted that the Rheumatic Fever Control Committee discussed the necessity for continuing the committee and the problem of obtaining a coordinator for the Rheumatic Fever Control Committee. Your Reference Committee considers that the problems involved might be resolved if the scope of the committee was broadened to include cardiac disease in general and recommends that this be done as it is in keeping with the sense of Resolution No. 31, the President's Five-Year Program as well as the recommendation concerning this committee made by Committee on Committees. The report of the Rheumatic Fever Control Committee is approved by your Reference Committee.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was supported and carried.*]

XVII—3e. MATERNAL HEALTH COMMITTEE

Your Reference Committee recommends the approval of the report, and that the Maternal Health Committee intensify its study to reduce maternal mortality.

Mr. Speaker:, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

XVII—3f. VENEREAL DISEASE CONTROL COMMITTEE

This report was studied and found to be very interesting especially in view of the increase noted in syphilis in Michigan of 21%, despite the efforts already being made for venereal disease control. Your Reference Committee approves the report and recommends that the educational campaign to control veneral disease should be intensified. The work of the Venereal Disease Control Committee deserves commendation.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

XVII—3g. TUBERCULOSIS CONTROL COMMITTEE

Your Reference Committee approves the report and particularly commends this committee for the recommendations contained in their report. Special attention is invited to their seventh and tenth recommendations which are that component societies establish or reactivate tuberculosis control or public health committees and that county medical societies devote at least one meeting every three years to the subject of tuberculosis.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

John G. Slevin, M.D.: Your Reference Committee invites your attention to the recommendation made by the Committee on Committees that the Venereal Disease Control and Tuberculosis Control Committees be combined into a Communicable Disease Committee thus broadening its scope of action.

XVII—3h. IODIZED SALT COMMITTEE

XVII—3i. OCCUPATIONAL MEDICINE COMMITTEE

XVII—3j. MENTAL HEALTH COMMITTEE

These three reports were reviewed and approved.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was supported and carried.*]

XVII—3k. CHILD WELFARE COMMITTEE

The Reference Committee approves the report and wishes to commend this committee for performing an excellent community service. Your Reference Committee considers the work of the Child Welfare Committee to be the kind of public relations that best exemplifies Medicine's service to the public.

Mr. Speaker, I move the adoption of this portion of the report.

The Vice Speaker: Support?

[*The motion was duly seconded and carried.*]

XVII—3 l. GERIATRICS COMMITTEE

This report was approved with the exception of Item 6 (page 122 of the Handbook). The Committee reserves approval with regard to the pilot study being conducted in the Grand Rapids area until it is determined whether the screening of Old Age Assistance persons is being conducted by a private practitioner of medicine or as a public health project. The committee wishes to be sure that there is no encroachment by this pilot study on private practice. The committee also notes that the Geriatrics Committee was active in Michigan's White House Conference on Aging and believes that the House of Delegates should encourage the committee to rebut the Michigan report at the White House Conference next January.

Mr. Speaker, I move the adoption of this portion of the report with the exception of Item No. 6 of the Geriatrics Committee's Report.

The Vice Speaker: Is there support?

[*The motion was duly seconded and carried.*]

XVII—3m. COMMITTEE ON DIABETES CONTROL

XVII—3n. PUBLIC RELATIONS COMMITTEE

XVII—3o. ETHICS COMMITTEE

These three reports were considered and approved.

Mr. Speaker, I move the adoption of this portion of the report.

THE VICE SPEAKER: Is there support?

[*The motion was duly seconded and carried.*]

XVII—3p. LEGAL AFFAIRS COMMITTEE

The committee is to be commended for its extensive activities and hard work which has been most helpful to the memberships of MSMS in protecting our interest. It should be brought to the attention of the members that because of the activities of the Legal Affairs Committee in reviewing 122 bills presented to the State Legislature, covering a variety of medical problems, that no legislation inimical to the medical profession was passed at the last legislative session. Your Reference Committee approves the report of the Legal Affairs Committee.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

JOHN G. SLEVIN, M.D.: Your Reference Committee recommends that each Annual Report indicate the number of meetings held by each committee during the year to show how active the committee has been and that committee recommendations be summarized.

Mr. Speaker, I move the adoption of the entire report.

[*The motion was duly seconded and carried.*]

THE VICE SPEAKER: Dr. Slevin, I wish to express the thanks of the chair for your excellent report and consideration of your subject material.

RALPH A. JOHNSON, M.D.: I would like to take this opportunity to introduce two modest observers we have from the Hoosier State. I would like to present Dr. Earl Mericle, President of the Indiana State Medical Society, and Mr. James Waggener, Executive Secretary of the Indiana State Medical Society. With typical Hoosier modesty, they prefer to remain in the balcony.

THE VICE SPEAKER: Gentlemen, you are most welcome, and I hope the members of this delegate floor will certainly facilitate your stay and pleasure here.

THE VICE SPEAKER: It has been brought to my attention that we have been favored with the presence of J. C. Allison, M.D., who is the Assistant Secretary of the Ontario Medical Association. On behalf of the Society, I would like to welcome you very much, Dr. Allison, to our deliberations, and may you please feel free to enter into any of our resolutions committees for attendance and perusal.

XVII—4. REFERENCE COMMITTEE ON REPORTS OF SPECIAL COMMITTEES

XVII—4a. SCIENTIFIC RADIO COMMITTEE

K. T. MCGUNEGLE, M.D.: The committee's work was reviewed as published in the Handbook and was commended for doing its work so admirably within the budget established for it.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

XVII—4b. ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

This work was reviewed as printed in the Handbook, and the committee was commended for its work.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

XVII—4c. ADVISORY COMMITTEE TO MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

This committee's work was reviewed as printed in the Handbook, was approved and the committee commended.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

XVII—4d. COMMITTEE ON STUDY OF PREVENTION OF HIGHWAY ACCIDENTS

This committee's work was reviewed, as printed in the Handbook, and the committee commended. The Reference Committee was disturbed by the apparent lack of response of the automobile manufacturers when urged to incorporate safety features in their products. The committee recommends that The Council write to such manufacturers deploring the present status and that suitable publicity be given to said letters.

Mr. Speaker, I move the adoption of this portion of the report.

THE VICE SPEAKER: Is there support?

[*The motion was duly seconded and carried.*]

XVII—4e. HOUSE OF DELEGATES COMMITTEE TO REVIEW THE FINANCIAL STRUCTURE OF MSMS

This report, hereafter, will be known as the Engelke Report. Much of it is factual information. The committee studied this report in detail and wishes to bring a few points to your attention, namely, one on page seven, this statement:

"A rough analysis of the cost of this study—referring to the relative value study—would seem to remind us that some House of Delegates actions cost a lot of money and should be very well thought out."

The committee particularly approved of that statement.

The budget of the Society was considered in detail, and it was pointed out that certain cuts in the budget were possible if the Society preferred to reduce its services to a concomitant degree.

On page 18, the question of maintaining what are considered adequate reserves was discussed thoroughly, and your Reference Committee concurs with the report that an effort should be made to maintain reserves even throughout the period of new building construction and cost retirement.

The committee reviewed the headquarters building costs and plans and agreed that they were both necessary and unavoidable, and recommends that the building be used for as many Society functions as are feasible and practical.

The committee also discussed the philosophy of borrowing to pay for the completion of the building, and concurred that it was more desirable to handle it in this fashion than to attempt to pay it off in a shorter time.

The committee then reviewed the conclusions of the Engelke Report which are one page long, and I would like to read them.

1. The officers and professional staff of the MSMS are to be commended again for their leadership in a program which is sound and well-administered.

a) The AMA delegates and alternates as well as members of The Council, committees and others active in the Society make a very valuable contribution to the public and Society welfare at a significant personal sacrifice in most instances.

b) The part-time officer and full-time key professional staff salaries are conservative. Other salaries and benefits are standard for comparable work.

2. The MSMS dues picture over the past few years, while conservative, has permitted the Society to maintain

its leadership among other state societies in matters of national and universal interest. This financial support has also permitted the Society to provide excellent state and local education and to provide extraordinary services to the public and to its member physicians.

At the same time, the Society has been able to provide appropriate quarters for its many activities without too much financial strain.

Rising costs cannot be ignored, however, here as elsewhere. A dues increase will be required to continue the orderly progress of the Society. The committee recommends a ten dollar increase to $75.00 per year starting at the beginning of 1961. This should permit a continuation of MSMS activities at their present level with the accumulation of reserves to meet unforseeable emergencies and should permit paying off the loan on the building in about six years. The committee recommends a dues increase rather than an assessment because dues are income tax deductible.

We quoted directly from the Engelke Report because we felt it was presented more ably than we were able to do in the short time we had.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded.*]

RALPH R. COOPER, M.D.: I would like to ask a question. The report of the Engelke Committee seems to indicate that the present $65 dues are to continue indefinitely. If my memory serves me correctly, when we agreed to have the graduated increase assessment of $5, $10, $15 over a period of five years, this was to terminate automatically in 1961. I don't believe there has been any action of the House to continue this beyond 1961. Therefore, I would like information on that point. If I am right, this automatically discontinues. Then the figure of $75 would actually mean a $25 increase rather than a $10 increase.

THE VICE SPEAKER: Would you care to clarify this situation?

KEATE T. MCGUNEGLE, M.D.: The statement is the committee recommends a $10 increase to $75 per year starting at the beginning of 1961. It is the committee's understanding that the $15 continues through 1961, and we went no farther than 1961.

RALPH R. COOPER, M.D.: All right, I would like to ask the Chair what the status of that $15 raise is. Was it to end in 1961?

THE VICE SPEAKER: Yes, according to the present action this would end in 1961. Action would have to be taken by the House. I would like to ask Dr. Engelke to comment on this.

OTTO K. ENGELKE, M.D.: Mr. Chairman, Members of the House and Guests: It was the committee's opinion that this action would establish the dues of the Michigan State Medical Society at $65 beginning in 1961. It was not the committee's opinion that this $10 raise was for 1961 only. The committee disagrees with the doctor who just spoke when he says that this, in effect, makes for a $25 increase in dues.

The committee believes that this is just what the committee said it was, a $10 increase in dues. The dues currently are $65. We are recommending that they be made $75.

If in 1961 the philosophy of the doctor holds, then you would have a dues reduction in 1961 of $15. This was not the idea of the committee. We believe that the language, however, I believe, I shouldn't say we. I can't speak for the other committee members. We haven't studied this lately. I believe the language might be improved somewhat. However, I would like to point out again that when this House establishes the dues at $75 as is established in this report, that any action it took prior to this time no longer applies. That is, whenever we pass legislation, we don't have to carefully go back and review every piece of legislation that was pertinent through the years that was passed.

I think this is a decision the House can make right now. If something can be done to clarify the language, I think this could be done by adding a clause to the effect **that the dues be increased $10 to $75 beginning in 1961 and subject to any** subsequent action of the House. I think that would cover it. This was the sense of the committee.

THE VICE SPEAKER: Would you care to so move as an amendment?

OTTO K. ENGELKE, M.D.: I will move.

[*The motion was supported.*]

THE VICE SPEAKER: Now we are open for further discussion of this amendment.

THOMAS J. DILLON, M.D. [Van Buren]: A motion to refer takes precedent over a motion to adopt. Because of the fact the chairman has stated the members of his committee are not conversant with the wording, I move that this be recommitted for further evaluation.

[*The motion was duly seconded.*]

OTTO K. ENGELKE, M.D.: I think the committee is perfectly familiar with the language of this report. It had their complete endorsement. They have read it and understand it thoroughly. All I am suggesting is language that might clarify some of the points. Since the philosophy of the committee will be just exactly that which I suggested, this represents no change in the committee's philosophy.

RALPH R. COOPER, M.D.: Mr. Chairman, I am a little thick, I am afraid, but I still don't know whether after 1961 my dues would be increased by $10 or $25. I am afraid it would be $25, so I would still like to have it recommitted, to have the thing clarified in language that I can understand.

HAROLD A. FURLONG, M.D.: Mr. Speaker, I believe that there is some misunderstanding here. I was the chairman of the Reference Committee. I think it was in 1957 when The Council was asking for a $15 increase in the dues for that year. We compromised for a $5 increase for one year, $10 for the next year and $15 for the next year. Then that was to expire. So I think that some provision must be made to carry on that $15 beyond 1961 if you want to raise the dues to $75. I think the suggestion that this be recommitted to the committee is a very wise thing because that should be cleared up.

I would be in favor of recommitting this matter to the committee until they can investigate and see if we are not right about that.

OTTO K. ENGELKE, M.D.: I think that if my memory serves me correctly, what we are discussing is a motion now to refer.

THE VICE SPEAKER: Refer this back to the committee for further investigation.

OTTO K. ENGELKE, M.D.: I think the sense of the committee could be made quite clear without such a referral. Just recognize the powers of the House of Delegates to establish the dues in this organization from time to time without the necessity of reviewing previous actions of the House of Delegates. If the House were to simply say that effective the beginning of 1961 the dues of this Society would be $75, this would be the sense of the committee. I don't think that requires a referral. You will accomplish what the committee wanted, and that was to give the Society ample funds to operate.

It would not be a $25 increase in dues. It would be a $10 increase in dues effective in 1961. To be sure, it wouldn't be the $15 reduction that was planned in 1956 before 1960 needs were known, but it would be a $10 increase. However, to make the language quite clear, I think all we have to say, and I think we have all the power in the world to say it, is that effective the beginning of 1961 the dues be $75.

KEATE T. MCGUNEGLE, M.D.: Mr. Speaker, the recommendation of the committee regarding this matter is one sentence. The committee recommends a $10 increase to $75 per year in dues starting at the beginning of 1961.

DE VERE R. BOYD, M.D. [Muskegon]: I think we are a little bit in error in our knowledge of what has been

done. It is the impression of my constituents and myself that as Dr. Furlong mentioned, that the assessment was supposed to have been paid up in 1961. If so, then our dues should be $60 a year instead of $75.00.

THE VICE SPEAKER: We are voting at this time on the motion to return this to the Reference Committee for further deliberation.

The motion was put and was defeated.

THE VICE SPEAKER: Now we are voting on the amendment to the effect that your dues are $75 a year.

CLARENCE I. OWEN, M.D.: Mr. Chairman, I don't believe that anyone here should go back to their constituents and tell them that they voted tonight to raise the dues to $75. Already your constituents expect the dues to be reduced back to $50. If you say they are going to $75, you will tell them you voted a 50% increase in dues which is exactly what you will be doing.

It is high time, gentlemen, that we economize, that we take some cognizance of the fact that there is some end to money some place. True, $25 doesn't sound like very much. We could all pay it, but I have heard no effort on the part of our State Society to economize. I have heard no effort on the part of our State Society to get some voluntary contributions for the building.

In Wayne County we were very successful. We had some very substantial voluntary contributions from our members. We eventually had an assessment, but a great portion of our building was paid by voluntary contributions.

We have made no effort along this line whatsoever, and I would urge you gentlemen to defeat this motion to increase our dues at this time.

PAUL T. LAHTI, M.D.: I would disagree with Dr. Owen. I think this is not a time to economize. Those of us who listened to Nixon and Kennedy just now realize there is still a great battle ahead. I think the Campaign for Freedom and all the other campaigns that our State Society has promoted in the last year are going to take more and more money. I don't think that any of us has to worry about a $15 or $20 increase.

It is not much more than you spend to go out for dinner one night in the year. I think the reason that some of the labor unions are so strong is because they have money in the treasury. If we are going to maintain our position as leaders in the medical profession, and maintain a strong State Society, I think we need money in the treasury. I would, therefore, support the motion that the dues be $75 a year.

THE VICE SPEAKER: You are now voting on whether your dues will be $75 a year. All those in favor say "aye"; those opposed "no." The motion is carried.

That is the amendment. Now we have to pass on the main motion.

The main motion was put and carried.

KEATE T. MCGUNEGLE, M.D.: The committee further recommends that an abstract of this report be printed in the Journal as soon as possible for the benefit of the entire membership.

Mr. Speaker, I move for the adoption of this recommendation.

[*The motion was duly seconded and carried.*]

KEATE T. MCGUNEGLE, M.D.: The committee also recommends that another finance study committee of the House be established in three years to function as have the committees of 1956 and 1960.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

KEATE T. MCGUNEGLE, M.D.: Paragraph 3 recommended the study of the establishment of a "ways and means" type of reference committee of the House of Delegates.

This committee spent considerable time discussing the means by which that may be done. They approved very strongly the thought behind it, and since the committee must meet again, they took no action with the assumption that tomorrow we will bring in a resolution attempting to solve this rather complex problem.

There is no recommendation on paragraph 3.

Mr. Speaker, I recommend the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

KEATE T. MCGUNEGLE, M.D.: Mr. Speaker, I move the adoption of this portion of the report as presented so far.

[*The motion was duly seconded and carried.*]

THE VICE SPEAKER: Thank you very much, Doctor, for this report and your careful consideration.

XVII—5. REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS

XVII—5a. RESOLUTIONS 10 AND 22 RE POSTGRADUATE MEDICAL EDUCATION COMMITTEE

RALPH R. COOPER, M.D.: No. 22 was No. 51 from the 1959 session. It was entitled: Committee on Postgraduate Medical Education.

Resolution No. 22 was disapproved. We approved Resolution No. 10 in principle, with the deletion of the phrase, "That the chairman would be the director of the Department of Postgraduate Medicine at one of the Medical Schools in the state." We propose a Bylaw change to implement this as follows:

"RESOLVED: That Chapter II, Section 2 of the Bylaws be changed to read, that the Committee on Postgraduate Medical Education shall consist of a chairman in addition to twelve members, that among the members shall be included the heads of the departments of Postgraduate Medical Education for each of Michigan's Schools of Medicine. The deans of each medical school or a representative chosen by them, the past chairman of the Committee on Postgraduate Medical Education, and a representative of the Michigan Department of Health shall be among those invited to serve in an advisory capacity. Four of the twelve members shall be appointed each year to serve a three-year term."

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was supported and carried.*]

XVII—5b. REPORT OF THE SPECIAL COMMITTEE TO STUDY THE ELECTION OF COUNCILORS ON GEOGRAPHIC BASIS AND THE STATUS OF COUNCILORS AS VOTING MEMBERS OF THE HOUSE OF DELEGATES WITH RESOLUTIONS NOS. 11, 12, 13 AND 44

Resolutions 11 and 12 were disapproved since The Council acts as an interim body for the House of Delegates, and it was thought therefore that confusion of responsibility would result if Councilors were elected by popular vote. It was also felt that if the Councilors were not elected by popular vote, that they should not be granted a vote in the House of Delegates. Resolution 13 was amended by deleting the phrase, "and provided further that no more than eight Councilor terms shall expire normally in any annual session." This was merely for clarification.

Resolution No. 13 as amended was then approved.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, action was postponed.*]

RALPH R. COOPER, M.D.: Resolution 44 was approved.

THE VICE SPEAKER: This is an amendment to the Constitution, and therefore will have to lay over for one year. Therefore, no action can be taken at this Session.

XVII—5c. PETITION FOR REVOCATION OF CHARTER RESOLUTION NO. 14 ON CLARIFICATION OF THE MICHIGAN STATE MEDICAL SOCIETY BYLAWS

The resolution was approved as submitted.

The resolve of that is now in the report. Perhaps I should read it. It changes a word.

"Petition for the revocation of charter of any component county society may be filed with The Council by a Councilor of the District within which *each* society is located, etc."

That is the way it is printed now. It should be changed according to the motion to:

"Petition for the revocation of charter of any component county society may be filed with The Council by a Councilor of the District within which *such* society is located, etc."

The way it is now in the book, every county society would have to file. We feel this was a misprint and should be changed from "each" to "such" for clarification.

I move the adoption of this portion of the report.

[*The motion was duly seconded, action was postponed.*]

XVII—5d. RESOLUTION NO. 18 ON CONSISTENCY OF COUNTY-MSMS BYLAWS

This was discussed and the "Resolved" was amended to read:

RESOLVED: That Chapter I, Section 1 of the Bylaws of the Michigan State Medical Society shall be changed to read "The Charter of each component county society shall be authorized by the House of Delegates and signed by the President and Secretary of the Michigan State Medical Society. Such Charter shall require that the Constitution and Bylaws of such component county society be at all times consistent with the provisions of the Constitution, and Bylaws of the Michigan State Medical Society, and with any amendments thereto hereafter adopted."

The Vice Speaker: Since this is a change in the Bylaws it will have to lay over for one meeting before we can take action on it.

XVII—5e. RESOLUTIONS 20, 21 AND 23 DEALING WITH THE ELECTION AND VOTING POWER OF THE SECRETARY AND TREASURER

Resolutions 20 and 21 were disapproved because it was felt that because of the special qualifications necessary to perform the duties of the Secretary and Treasurer, it would be better if the present method of election were continued. Resolution No. 23 was amended to read:

"RESOLVED: That the Constitution of the Michigan State Medical Society be amended by deletion of the phrase in Section 1, 'With the Secretary and the Treasurer, the last two being elected by the foregoing,' and by the addition of a new Section 2, 'It shall elect a Secretary and Treasurer who will serve without the right to vote.' The present Section 2 would be renumbered Section 3."

This motion has been laid over since last year. This represents merely word changing for clarification.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was supported and carried.*]

Ralph R. Cooper, M.D.: We next considered the Annual and Supplemental Reports of the House of Delegates Special Committee to Review Constitution and Bylaws. Several amendments were made to the report as printed, mostly for the sake of clarification or errors in copy.

XVII—5f. ANNUAL AND SUPPLEMENTAL REPORTS OF SPECIAL HOUSE OF DELEGATES COMMITTEE TO REVIEW CONSTITUTION AND BYLAWS

On page 1, Section (c) of the Supplemental Report of this Special Committee there is a typographical error. The words "Section 4" are changed to read "Section 5 to Chapter 16" and in the next line, the words "Section 4" are changed to "Section 5." This is an error in numbering because additional sections had been added to Chapter 16 in the interim.

On page 2, no action was taken on Sections (d), (f), (g) or (j) because of previous recommendations of this committee. In Section (h), line 4, the word "dismissal" was changed to read "dismissal or."

Page 3, Sections (l) and (m), no action was taken because of previous recommendations of this committee. Item 1 at the bottom of page 3 of the Special Committee's report was amended to read "Amend Section 1 of Chapter 10 to read as follows: 'The Council is the Executive Body of this State Society, subject only to the following. It shall determine the times and places of its meetings. It shall hold an Annual Meeting in January of each year at which time it shall elect a Secretary, a Treasurer, and an Editor of the Journal of the Michigan State Medical Society, each to take office immediately and to serve for a term of one year or until his successor is elected and takes office. At its first meeting following the Annual Meeting of the House of Delegates, it shall elect a Chairman, a Vice Chairman, a Chairman of the Finance Committee, a Chairman of the County Societies Committee and a Chairman of the Publications Committee, each to take office immediately and to serve for a term of one year or until his successor is elected and takes office.'

I might say parenthetically that this is merely to put in words the procedure that I understand is actually being done at the present time.

Items 2, 3 and 4 on page 4 of the Special Committee's report were left as printed in the report. The recommendation for the reappointment of a committee of the House of Delegates to Review Constitution for next year was approved.

Mr. Speaker, I move the approval of this portion of the report.

[*The motion was duly seconded.*]

The Vice Speaker: Hearing support, is there any discussion? If none, all in favor say "aye"; opposed "no." It is carried.

Ralph R. Cooper, M.D.: Mr. Speaker, I move the adoption of the entire report with the elimination of those parts that have to lay over until tomorrow or the next meeting.

The Vice Speaker: We have one to the Bylaws that carries over until the next meeting and one change in the Constitution that carries over for a year.

[*The motion was duly seconded.*]

Louis F. Hayes, M.D.: There are other resolutions that have to lay over one meeting, too. Resolution No. 13 which has to do with change in Bylaws which was approved as amended, that should lay over until the next meeting as well as No. 14 which was approved and has to do with the change in the Bylaws.

There are a total of three resolutions having to do with change in Bylaws that should lay over one meeting and one resolution having to do with changes in Constitution from last year.

The Vice Speaker: These will also be carried over until our next meeting.

[*The motion was carried with commendation to the committee.*]

[J. J. Lightbody, The Speaker, resumed the chair.]

XVII—6. REFERENCE COMMITTEE ON SPECIAL MEMBERSHIPS

ASSOCIATE MEMBERS

J. Duane Miller, M.D.: I move that these persons be made Associate Members of the Michigan State Medical Society:

[*The motion was supported and carried.*]

ASSOCIATE MEMBERSHIP:

Genesee	Margaret Goetz, M.D.
Kent	Willis E. Gouwens, Jr., M.D.
	Russell G. Graff, M.D.
	Robert M. Eaton, M.D.
	Richard H. Meade, M.D.
Muskegon	Mr. A. T. Leonard—Psychologist
	Mr. James C. Carlson—Physicist
Oakland	Robert P. Hull, M.D.
	Mark S. Beaubien—Project Hope
Washtenaw	Joseph M. Abell, Jr., M.D.
	Eli C. Abramson, M.D.
	Walter M. Baird, M.D.
	William B. Baker, M.D.
	Robert F. Barnett, M.D.
	Richard J. Bartlett, M.D.
	Giles G. Bole, Jr., M.D.
	Roger Boles, M.D.
	Theodore W. Bywaters, Jr., M.D.
	Kenneth G. Campbell, M.D.
	Mary Ellen Clifford, M.D.
	Bruce Draper, M.D.
	William G. Findorff, M.D.
	John E. Finger, M.D.
	Howard E. Fink, Jr., M.D.
	William R. Forsythe, M.D.
	Jules A. Francoeur, M.D.
	Paul W. Gikas, M.D.
	Leonard M. Heinz, M.D.
	Philip B. Huizenga, M.D.
	James O. Johnston, M.D.
	Robert E. Johnston, M.D.
	Robert L. Kerry, M.D.
	William L. Kopp, M.D.
	Glenn O. Lease, M.D.
	Edwin H. Lewis, M.D.
	Hoke S. Nash, M.D.
	Harold A. Oberman, M.D.
	William D. Pletcher, M.D.
	Louis T. Plouff, M.D.
	James T. Post, M.D.
	Thomas H. Rea, Jr., M.D.
	Daniel S. Renner, M.D.
	David R. Rovner, M.D.
	Donald L. Schmidt, M.D.
	Mansfield F. W. Smith, M.D.
	J. Clyde Spencer, M.D.
	Walter M. Tabar, M.D.
	Philip Tager, M.D.
	Clarence H. Tannel, M.D.
	John H. Tedford, M.D.
	Charles D. Tourtellotte, M.D.
	Gordon L. Verity, M.D.
	May Louise Votaw, M.D.
	John B. Wear, M.D.
	John G. Weeks, M.D.
	Arthur S. Weston, M.D.
	Lawrence H. Wilk, M.D.
	Philip A. Zlatnik, M.D.
Wayne	A. Alan Agree, M.D.
	John D. Ausum, M.D.
	Dudley W. Byers, M.D.
	Robert I. Crawford, M.D.
	Abraham Elson, M.D.
	John W. Lawson, M.D.
	Eugene Meyer, M.D.
	Gerald D. Spero, M.D.
	Raymond E. Swanson, M.D.

J. Duane Miller, M.D.: I move the following be made Life Members:

[*The motion was supported and carried.*]

LIFE MEMBERSHIP:

Calhoun	Albert C. Dickson, M.D.
Chippewa-Mackinac	Harvey M. Harrington, M.D.
Clinton	Wells B. Fillinger, M.D.
	Charles T. Foo, M.D.
	Arthur C. Henthorn, M.D.
Genesee	Frederick E. Dodds, M.D.
	William S. Williams, M.D.
	Robert L. Phillips, M.D.
	Archibald C. Pfeifer, M.D.
Kalamazoo	Horace R. Cobb, M.D.
Kent	A. B. Smith, M.D.
	Wesley M. Burling, M.D.
	David B. Hagerman, M.D.
	Edward D. Hunderman, M.D.
	Harry Lieffers, M.D.
	Alexander M. Martin, M.D.
Saginaw	Lloyd C. Harvie, M.D.
	A. R. Moon, M.D.
St. Clair	Marion E. Bovee, M.D.
Van Buren	William R. Young, M.D.
Washtenaw	A. C. Furstenberg, M.D.
	C. H. Ross, M.D.
Wayne	Joseph Baker, M.D.
	Audrey O. Brown, M.D.
	George C. Burr, M.D.
	Malcolm D. Campbell, M.D.
	John M. Carter, M.D.
	Howard P. Doub, M.D.
	William N. Edmonds, M.D.
	Herbert E. Fogt, M.D.
	William J. Fulton, M.D.
	Nicholas Galdonyi, M.D.
	Leslie T. Henderson, M.D.
	William E. Henderson, M.D.
	J. Stewart Hudson, M.D.
	Joseph O. Kopel, M.D.
	John G. Mateer, M.D.
	Gordon S. McAlpine, M.D.
	Robert C. Moehlig, M.D.
	Henry C. Moritz, M.D.
	J. E. Pittman, M.D.
	Frank P. Raiford, M.D.
	H. Walter Reed, M.D.
	Clarence E. Reyner, M.D.
	Harry C. Saltzenstein, M.D.
	Ernest C. Schultz, M.D.
	George Sewell, M.D.
	Gerald A. Wilson, M.D.

J. Duane Miller, M.D.: I move the following be made Retired Members:

[*The motion was seconded and carried.*]

RETIRED MEMBERSHIP:

Bay	Thomas G. Wilson, M.D.
Barry	Stewart Lofdahl, M.D.
Berrien	Harold J. Cawthorne, M.D.
Genesee	Thomas N. Wills, M.D.
Grand Traverse	Clifford F. Brunk, M.D.
Oakland	John B. Engel, M.D.
Washtenaw	John B. Barnwell, M.D.
	Paul S. Barker, M.D.
	Stacy C. Howard, M.D.
	Leo A. Knoll, M.D.
Wayne	Theodore S. Fandrich, M.D.
	William J. Fulton, M.D.

The Speaker: Thank you and your committee for doing all this work, Dr. Miller.

XVII—7. REFERENCE COMMITTEE ON LEGISLATION AND PUBLIC RELATIONS

XVII—7a. RESOLUTION NO. 2

This resolution is in regard to the Election Campaigns.

LAWRENCE A. DROLETT, M.D.: Your committee voted to approve this resolution with the following amended "Resolved":

"That we go on record to individually work towards the defeat of these state and national candidates who either through political expediency or through conscious or subconscious desire to gain power are promulgating these socialistic and foreign ideas into our American heritage."

And the committee amended it to add:

"And actively support those candidates who have subscribed to the 10-point program of the AMA Committee on Aging, and be it further

"RESOLVED: That the resolution be publicized to the members of the Michigan State Medical Society."

I move the adoption of this part of the report.

[*The motion was seconded and carried.*]

XVII—7b. RESOLUTION NO. 8 REGARDING WAGES OF NURSES

The committee discussed this at length, and approved it. I move that the report be adopted as presented.

[*The motion was duly seconded and carried.*]

XVII—7c. RESOLUTION NO. 9 REGARDING NURSES TRAINING PROGRAM

The Resolved in this was:

"That schools of nursing be encouraged to study all aspects of the problem of the nursing shortage, to the end that there may be available for patient care more nurses" and here the committee amended. We struck out "trained in the practical aspects of nursing," and added **"—of all categories, and that the Michigan State Medical Society make every effort in programs of recruiting."**

Mr. Speaker, I move the adoption of this resolution as amended.

[*The motion was duly seconded and carried.*]

XVII—7d. RESOLUTION NO. 7, REGARDING THE BASIC SCIENCE LAW

Your Legislative and Public Relations Committee listened to discussion at length on this. We listened to advice from Dr. Dean Scott, Wayne State University School of Medicine. We heard from Dr. Troost. We heard from numerous members of the audience, and since this evening I have personally conferred with Dr. Hubbard, the Dean of the University of Michigan Medical School.

After discussing this resolution at length, it was agreed that the resolution should be rewritten, and a substitute resolution submitted to the House.

One of the members of our committee came up with what I thought was a masterpiece in a substitute resolution. It took the stigma off the fact that the Basic Science Law was a monster, it was not doing the doctors any good, but emphasized the fact of the increasing training that doctors are getting now, so I will read the substitute resolution as submitted by the committee.

Substitute Resolution on Repeal of Basic Science Law:

Whereas, the purpose of the basic science law was originally designed to insure the standards in training in the basic sciences of all licensed physicians, and

Whereas, the modern approved medical training programs assure the standards of training in the basic sciences, and

Whereas, the prolonged training period before practice of present day physicians frequently places them several years from their basic science training, even though fully qualified in these fields, and

Whereas, the basic science law therefore frequently becomes a deterring factor in attracting new and adequately qualified physicians from other areas to practice or to teach in Michigan, therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society go on record as favoring repeal of the basic science law and the enactment in its place of a uniform healing arts act, and be it further

RESOLVED: That The Council of the Michigan State Medical Society be instructed to have legislation to accomplish this resolution introduced into the Legislature of the State of Michigan.

Now this doesn't mean that this is going to be accomplished next year. We specifically left out 1961, and if you will permit me, Mr. Speaker, to discuss this for a moment, I move the adoption of this resolution.

[*The motion was duly seconded.*]

THE SPEAKER: There is a motion to adopt this substitute resolution. This has been seconded. The substitute resolution is now open for discussion.

LAWRENCE A. DROLETT, M.D.: Mr. Speaker, in my experience in the Legislature in Lansing, I think it would not be too difficult to get the Basic Science Law repealed, as far as the Legislators are concerned, because it would mean to them the abolition of a Board which they now support. Some of our opposition might come from the osteopaths. I don't know how much would come from the chiropractors, but so many times the Legislators have told me down there that they wish we had a Uniform Medical Practice Act such as is in existence now in Nebraska, Wisconsin and several other states, that might include perhaps the doctors and the osteopaths, and the control would be that it would be required to take this examination. They would have some representation on the Board.

Certainly it has long been recognized that our present Medical Practice Act which was written in 1899 has been amended and amended, and it is still somewhat out of date. It was proposed in the committee today that this might be a companion move, but certainly I don't think that there should be any effort to repeal the basic science law in the Legislature until there is an ironclad move to accompany it with a healing arts act, and that is so stated in the resolution.

FRANCIS P. RHOADES, M.D.: Point of information, Mr. Speaker. Could the chairman of the Reference Committee tell me, doesn't this confer equality? All those eligible to take the healing arts exam then would be equal as far as this act is concerned. It would confer quality on those who were eligible to take the exam, wouldn't it?

LAWRENCE A. DROLETT, M.D.: No, if we refer to what they have in Wisconsin and Nebraska, they would take the healing arts exam according to what they have been taught. I know they control them pretty well in Wisconsin.

For instance, I personally have a license to practice in Wisconsin. There is an osteopath's signature on the diploma, and he asked me one question when I was taking the oral examination. It was a pretty intelligent question, but it doesn't imply they are going to be open to practice medicine.

I think that we would have to have a lot of conferences with the osteopathic profession before this could pass through the Legislature.

CLIFFORD W. COLWELL, M.D.: What would that mean to reciprocity with those states?

LAWRENCE A. DROLETT, M.D.: As far as the basic science law is concerned, I think if we took it out, it might mean our reciprocity would be increased. With our present State Board of Registration in Medicine, we have reciprocity with 46 states—everybody but New York and Florida.

FRANKLIN L. TROOST, M.D.: Mr. Speaker, Members of the House of Delegates: Last evening we were addressed by our honored President of the State Society. He made this remark: "If we fail to provide the public with adequate medical care, we have no excuse if a Government agency does it."

Now this question of the basic science, of course, has been on the floor of this House many times. Before I came here, Washtenaw County in 1947 attempted to have it repealed. I believe once later. Ingham County in 1950 and 1951. The resolution was approved by the Reference Committee, but defeated in the House. In 1953 this House of Delegates took action to the effect there would be reciprocity with the other basic science states which numbered approximately nineteen. In 1955 the law was further amended that the basic science board may, at its discretion, waive the basic science examination if the candidate presents evidence that he has passed before any official examining board in the United States, which means state boards of registration in medicine, osteopathy, and chiropractic—he has passed this examination, and that the questions are comparable to those submitted by our board, and that he has received satisfactory grades.

I believe the law has been amended as much as it can possibly be. Now these amendments have eventually borne fruit—fruit in that in 1950 we had in the State of Michigan a total of 6937 doctors with a population of 6.3 million. Of this number, 5343 were engaged in private practice. In 1956, before the 1955 amendment had a chance to show itself, despite the fact that in 1953 reciprocity was effective in basic science, the Michigan population of doctors had gone up almost one thousand, to 7900. The population at that time was about 7.2 million, a gain of 900,000 people, but the population of doctors engaged in private practice had dropped in six years to 5168. It dropped some—175 men, despite a population gain of 900,000.

Now in 1958 the number of physicians had risen to 8187. The population was fully 7.5 million, and is now almost 8 million. We have finally gotten back to where we were in 1950. We had 5384 practicing doctors, compared to 5343, eight years previous. We had picked up 1,200,000 people with forty more doctors to serve them.

Now we, who favor repeal of the basic science law, do not claim our shortage of doctors which is very critical—by the way, in 1958 at Ann Arbor it was stated that we were thirty-fifth in the country on a population basis. In 1950 we were thirtieth. We are dropping every year.

Our failure is not due to the basic science law. One of our failures is that we cannot, with our present facilities, turn out enough medical graduates. We have only two schools, and it has been the history of this state that we have always supported more than half of our doctors. In fact, only 42% are educated in Michigan.

Now I said we have more or less reached the ultimate with these present amendments, but we are faced with another situation.

The National Board of Medical Examiners in 1959 gave certificates to 3300 of our young doctors, approximately 45% of those in the nation, and none of those doctors can come to Michigan—45% of them—unless they face a basic science examination, and on top of that an examination by the State Board of Registration in Medicine.

When it was my privilege to serve on the State Board of Registration in Medicine, we gave a very total examination, but in 1954 the Attorney General ruled that we must take a full examination.

What has brought this all about? This year in the spring one of our neurologists wanted to get a doctor in with him. He graduated from Northwestern and was trained at the Mayo Clinic in neurology. The Board of Neurology had licensed him in the State of Illinois. He wanted to come to Michigan.

He said, "Sure, you can come. First, take your basic science exam, pass it, and then wait until the time comes and take your State Board of Registration."

That is the situation we have been up against hundreds of times. In my years on the State Board I spoke to many, many of these people. Their attitude was: Why come to Michigan? There are plenty of other places to go.

This article was written in 1951 and published in The Journal of the Michigan State Medical Society. There are just a very few excerpts I want to read.

In 1940—we had 435 osteopaths. In 1950 with the basic science law in full effect, we had 907, and in 1960 we have 1600 out of 14,000 osteopaths in the country. We have one out of nine.

Regarding the chiropractors, I do not know. I know how many there were in 1950. There were 474 in 1950, but the influx of chiropractors has let up. Michigan has no more to offer chiropractors than any other state, but it has a great deal to offer osteopaths. The osteopathic laws are very liberal. That is why we have such a great influx, and also because of our tremendous shortage of doctors to practice.

The basic science law should be repealed on the basis that it keeps so many doctors from the state, and in my concluding remarks, in 1950 I wrote: Where are we going to secure the 1500 doctors we are now lacking? Where will replacements come from for the 150 to 200 Michigan doctors who die or retire each year? The answer as to where the needed doctors are coming from is that they are not coming, not until we become realistic and repeal the basic science law.

I believe that was well borne out in that we picked up only forty practicing doctors in eight years of population increase as it was.

This afternoon at the session, Mr. Speaker, Dean Scott from Wayne University spoke in favor of repeal of this law. Dr. Towsley of Ann Arbor spoke in the same vein, and this evening I have spoken to Dr. Hubbard, Dean of the University of Michigan Medical School.

There are some facets I did not enter into, and I request that the privilege of the floor be granted to these three doctors for a short period of explaining their position on it.

The Speaker: This request is granted if any of the three would wish to say something at this time.

Dean Hubbard [University of Michigan Medical School]: Mr. Speaker, thank you for the courtesy of the floor. I will keep my remarks as brief as possible.

It has been observed that the basic science law does not add to our assurance of the competency of our medical graduates, whether from the University of Michigan or from those other medical schools in the United States. The purpose of the basic science law, if it be the purpose to control the influx of other practitioners, is a hopeful view, but I think the bare facts indicate that this purpose is not accomplished. The large number of such practitioners that are now with us in this state would certainly suggest that they have not been kept out—not by the basic science law. The very construction of the basic science examinations are troublesome to a medical school educator since these fields have changed enormously and continue to change very rapidly. They have expanded tremendously, and one of the great issues in medical education is to select that material that is most pertinent for instruction and for examination, and as the Board is now constituted it has on it many who are totally unfamiliar with what goes on in a modern medical school.

Finally, I would suggest that if the purpose of this law is to insure that people of the state have the care that they are entitled to, then this function can be very well served by the State Board of Registration since it is set up in order to insure the people of this very care.

The issue of the National Board of Medical Examiners and its acceptance by the State Board of Registration may or may not be related to the basic science question.

I will add my urgent endorsement to extending the reciprocity of the state to those who hold certificates of the National Board. Thank you.

The Speaker: Thank you very much, Dr. Hubbard. Dr. Scott.

Dean Scott [Wayne University]: Mr. Speaker, thank you for the courtesy of the floor.

I think one of the questions to be asked is: Does the basic science law perform a useful function, or does it perform a disservice for the people of Michigan? I think

there is absolutely no conclusive evidence that shows that it performs a useful function. The corollary to that is that it may, and I personally believe it does, perform a disservice. Those of us who are asked to recruit physicians to teach in our medical schools are up against this basic science law barrier time and time again where a perfectly adequate person is denied the right to exercise his talents in the State of Michigan because of a basic science law which he does not choose to take, and in this matter he cannot be blamed.

There are many other respects to this problem, and in order to keep our discussion at a minimum at this late hour, I would merely like to add that the motion for the resolution which is put forward by your committee has my personal enthusiastic endorsement.

THE SPEAKER: Thank you, Dr. Scott.

[*The motion was put and carried.*]

XVII—7e. PRESIDENTS PROGRAM RESOLUTION NO. 25

Dr. Drolett: Resolution No. 25, at the bottom of the page under "C" the committee changed it to add after the end of "expediting plans which will" we added "hope to." We added that.

Over on the next page under paragraph 1, on line 2, "said increase to be attempted," not "accomplished" over the period of time beginning in September 1960.

Under the second resolved, in the line 2, the word "headed" was changed to "promoted".

* * *

With this amendment to the Resolution 25, Mr. Speaker, I move the adoption of the resolution as amended.

[*The motion was duly seconded and carried.*]

XVII—7e. RESOLUTION NO. 26

DR. DROLETT: The first resolved was amended to read as follows:

"RESOLVED: That the Presidents Program of the Michigan State Medical Society include an effort to promote the securing of complete coverage of this state by full time qualified personnel in local health departments, and be it further—"

* * *

Mr. Speaker, I move the adoption of this resolution 26 as amended.

[*The motion was duly seconded and carried.*]

XVII—7e. RESOLUTION NO. 27 RE BASIC RESEARCH

DR. DROLETT: In the third line of the second "Whereas" at the end of the second line where it says, ". . . to methods of medical treatment major breakthroughs in basic medical knowledge, . . ." we changed that to read, ". . . new advances in medical knowledge." We struck "major breakthroughs," and changed it to "new advances in medical knowledge."

In the fourth line of the first "Resolved" the line reads, ". . . direct their funds for basic research," and the committee changed it to read ". . . in biological sciences and especially fields pertinent to medical science, . . ."

Amended Resolution No. 27 Re Presidents Program: Basic Research:

Whereas, history proves that basic advances in medicine come only through the route of basic research of which the discovery of penicillin is one example, and

Whereas, although clinical research attempts to solve specific disease problems and provide valuable contributions to methods of medical treatment, new advances in medical knowledge are accomplished, in the main, as a result of basic research, and

Whereas, scientists the nation over, as well as medical schools, lament the fact that so great a proportion of available funds are for limited research, therefore be it

RESOLVED: That the Michigan State Medical Society incorporate in its President's Program an effort to inform the public of the need for unrestricted research grants and to encourage individuals, foundations and governmental agencies to direct their funds for basic research in biological science and especially fields pertinent to medical science, and be it further

RESOLVED: That the following organizations and others of like mind be requested to cooperate with Michigan State Medical Society in this program:

University of Michigan
Wayne State University
University of Detroit
Michigan State University
Research Foundations both state and national

* * *

Mr. Speaker, I move that Resolution No. 27 as amended be adopted.

[*The motion was duly seconded and carried.*]

XVII—7e. RESOLUTION NO 28 CONCERNING MATERNAL AND CHILD HEALTH

DR. DROLETT: "Whereas, despite remarkable progress in the lowering of rates of maternal," and we added "and infant mortality, maternal and infant deaths are still a medical problem . . ." those two words were added by the committee. We completely struck out the second "Whereas" and down under the No. 2 of the first "Resolved" over at the end of the first line of paragraph two, we added the words "maternal and child health committees. . . ."

Amended Resolution No. 28 re Presidents Program: Maternal and Child Health:

Whereas, despite remarkable progress in the lowering of rates of maternal and infant mortality, maternal and infant deaths are still a medical problem in Michigan, therefore be it

RESOLVED: That the Presidents Program of the Michigan State Medical Society include a program providing for the following:

1. Expansion of the use of the perinatal mortality register.

2. The institution of county medical society maternal and child health committees in those counties where they do not presently exist, and the stimulation of these committees in those societies where such committees do exist.

3. The development of expectant parent classes and other varieties of instruction beginning in the secondary schools and extending up to and including adult education programs.

4. Continuing publication in the Journal, MSMS, of Obstetrical Brevits and other scientific materials regarding maternal and child health and the distribution of information of an appropriate nature through news media and other publications to the lay public; and be it further

RESOLVED: That the following organizations, and others of like mind, be requested to cooperate with Michigan State Medical Society in this program:

Michigan Department of Health
Michigan Association of Public Health Officers
Michigan Department of Public Instruction
Michigan Academy of Pediatrics and other specialty organizations

* * *

Mr. Speaker, I move the adoption of this resolution as amended.

[*The motion was duly seconded and carried.*]

XVII—7e. RESOLUTION NO. 29

As presented to the committee, this resolution was approved without change. I move adoption of Resolution No. 29.

[*The motion was duly seconded and carried.*]

XVII—7e. RESOLUTION NO. 30

In line six of the second "Whereas" over at the corner reads, "... personal health supervision designed to make best use of," and we inserted there "of medical knowledge of the calendar," explaining that it was pointed out by one member of the committee that doctors might be the best ones to know when people were to be vaccinated, immunized, and so forth.

Under the second "Whereas" it is to read now, "Whereas, the public and the profession," and we struck out "are making adequate," and substituted, "may improve and increase."

Over on the second page under line 5, paragraph 5, "The concept of continuous personal health supervision to make best use of medical knowledge of the calendar of biologic mishaps . . ." we added "medical knowledge of the calendar of".

Under "Resolved" that the following organizations, or organizations of like mind, we added "with skills and experience in this area."

Amended Resolution No. 30 re Presidents Program: Early Detection of Disease:

Whereas, early detection of disease provides greater opportunity for success in the subsequent application of medical knowledge to the end that many lives would be saved and health prolonged, and

Whereas, many new and effective means for early detection and diagnosis of disease are now available such as the "Papanicolau Smear" for malignant and non-malignant disease of the female genital tract; screening programs in schools for the early detection of vision and hearing defects in children; periodic health appraisals based upon time intervals and/or continuous personal health supervision designed to make best use of medical knowledge of the calender of biologic mishaps for preventative procedures; x-ray tests and skin tests for tuberculosis; routine urinalysis for sugar and blood glucose determination for diabetes, and

Whereas, the public and the profession may improve and increase use of the opportunities for early detection and diagnosis of disease; therefore be it

RESOLVED: That the President's Program of the Michigan State Medical Society emphasize, encourage and promote:

1. The use in the doctor's office of cytologic diagnosis for the early diagnosis of the female genital tract and research aimed at extending its use to other anatomic areas.
2. The use in the schools of screening programs for the detection of vision and hearing defects.
3. The use in hospitals and doctors' offices of skin testing and pre-employment and prehospital admission x-ray.
4. The expansion of venereal disease detection facilities.
5. The concept of continuous personal health supervision to make best use of medical knowledge of the calendar of biologic mishaps for making physical evaluations of the patient thereby providing an opportunity for early detection, as well as the concept of periodic health appraisals.
6. The taking of urinalysis for sugar on all patients and the reporting of new cases.
7. Other means for early detection which are now known or will become known to medical science; and be it further

RESOLVED: That the following organizations or organizations of like mind with skills and experience in this area be requested to aid in this effort:

All County Medical Societies
The American Cancer Society
The Michigan Cancer Foundation
The Michigan Tuberculosis Association
Michigan Diabetes Association
Michigan Department of Health
Michigan Health Officers Association
Michigan Public Health Association

* * *

I move that Resolution No. 30 as amended be adopted.
[*The motion was duly seconded and carried.*]

XVII—7e. RESOLUTION NO. 31

In the fourth "Whereas" line 2 we added the word "... be resolved by increased effort;" in the fifth "Whereas" line 2, we added "... can be further aided by the Michigan State Medical Society. . . ."

[The fourth and fifth "Whereas" were amended to read as follows]:

"Whereas, the above are but a few examples of diseases and situations which exist and which can, with present knowledge, be resolved by increased effort, and

"Whereas, those committees and agencies who are working upon disease control programs can be further aided by the Michigan State Medical Society and its component district and county societies; therefore be it . . . "

* * *

I move the adoption of Resolution No. 31.
[*The motion was duly seconded and carried.*]

XVII—7e. RESOLUTION NO. 32

Under the third "Whereas."

"Whereas the psychiatrists have repeatedly," and we struck out the words "expressed their willingness to, . . ." so it reads now, "Whereas, the psychiatrists have repeatedly shared their specialized knowledge with their fellow practitioners of medicine . . ." and then under the first "Resolved" in line 2, "include additional projects on mental health, . . ." and then down to the third paragraph we completely changed that to read, "The encouragement of medical schools in further development of home care training programs as well as the encouragement of physician cooperation," and in No. 4 we added under the first line, "The increased development of plans. . . ."

Amended Resolution No. 32: President's Program: Mental Health:

Whereas, mental illness and mental health are major factors in adding to the life expectancy of the people as well as increasing the happiness of these people during the additional years, and

Whereas, every doctor of medicine is afforded opportunities to treat mental illness or protect the mental health of his patients in his day-to-day practice, and

Whereas, the psychiatrists have repeatedly shared their specialized knowledge with their fellow practitioners of medicine as well as with the general public, and

Whereas, every patient needs to be considered as a whole person recognizing his mental and environment needs as well as those of a physical nature; therefore be it

RESOLVED: That the President's Program of the Michigan State Medical Society include additional projects on mental health involving, among other activities, the following:

1. Notice to other MSMS committees of the desire of the Mental Health Committee to be of assistance to them upon request.
2. The establishment of psychiatric units in additional general hospitals where adequate psychiatric personnel are available.
3. The encouragement of medical schools in further development of home care training programs as well as the encouragement of physician cooperation.
4. The increased development of plans to improve the non-hospital care of mentally disturbed older persons.
5. A study of the desirability of additional nursing homes qualified to care for mild psychiatric cases and the improvement of same, and be it further

RESOLVED: That the following organizations and organizations of like mind be encouraged to participate with MSMS in this program:

Michigan Department of Mental Health
Michigan Mental Health Association
Michigan Psychiatric Association
Wayne State University
University of Michigan
Governor's Commission on Aging
MSMS Mental Health Committee
Michigan Department of Health
Visiting Nurse Association
Nursing Home Association

* * *

I move for adoption the amended resolution No. 32, Mr. Speaker.

[*The motion was duly seconded and after discussion, was carried.*]

XVII—7e. RESOLUTION NO. 33

Lawrence A. Drolett, M.D.: In the second line of the "Whereas," we struck out "and one reason for this is," and substituted "because of."

In the fourth "Whereas" in the third line we struck out "replace," and put "in place of."

In the fourth line of the sixth "Whereas," we struck "social, political and economic," and replaced it with the words "socio-economic."

In No. 1 in the first "Resolved," we put "continued" dissemination of knowledge to the medical profession, and over on the next page we replaced "philosophies" with "advancements."

In No. 2 we inserted "increased," after "The." "The increased holding of joint committees . . ." and then we added a sixth paragraph to this which reads as follows:

"Cooperation with visiting nurse agencies, health department, et al in a program to provide proper home care in paramedical fields."

Amended Resolution No. 33:

Whereas, there is an increasing number of individuals in a community having chronic disabilities because of the prolonging of life due to the advancement in medical science, and

Whereas, this is a continuing situation involving social, economic, psychological, and medical problems for the patient, his family and the community, thereby requiring cooperation from many professions, occupations and businesses and needing the leadership of the medical profession, and

Whereas, early recognition by the doctor of medicine of rehabilitation potentials of the patient, before disability is culminated, can markedly aid in the prevention of minimizing of the effect of the potential disability, and

Whereas, great social, economic and medical gains can be made toward replacing the ignominy of dependency with the dignity of self-determination, and ability in place of disability, if the patient is followed until he is as close to his potential as possible, and

Whereas, the investment of time by the professions, and money by voluntary and when necessary, governmental agencies in a program to effectuate greater physical and social independency of the chronically disabled is desirable from socio-economic standpoints, therefore be it

RESOLVED: That the Presidents Program take cognizance of the responsibilities and opportunity inherent in this situation and encourage, sponsor or promote the following program:

1. The continued dissemination of knowledge to the medical profession, to related organizations and to communities of the techniques and advancements of medically proven policies of rehabilitation.

2. The increased holding of joint meetings of county medical society and community leaders for the planning of community projects and public presentations to demonstrate the values of and the progress in rehabilitation.

3. The encouragement of undergraduate and postgraduate seminars on rehabilitation methods within and in connection with, medical and paramedical schools as well as the concept of chronic disability field clinics through the state.

4. The endorsement of a survey to define areas of need for the establishment of additional rehabilitation services and the encouragement of the subsequent establishment of such programs, where needed.

5. Cooperation with the Michigan Hospital Association in a program to effectuate the easy transfer of patients from hospitals to medical rehabilitation centers and return, and be it further

RESOLVED: That the Program promote cooperation with visiting nurse agencies, health departments et al in a program to provide proper care in paramedical fields; and be it further

RESOLVED: That the Michigan State Medical Society request the assistance, in the furthering of this program of the following, and like-minded, organizations:

Division of Vocation Rehabilitation,
Michigan Department of Public Instruction
Michigan Crippled Children Commission
County and State Welfare Departments
Detroit Academy of Orthopedics
Michigan Orthopedic Society
Michigan Academy of Physical Medicine
Michigan Society for Crippled Children and Adults
United Cerebral Palsy Association of Michigan
Rotarians
Health Department
Visiting Nurse Association
Elks
Lions
Michigan Rehabilitation Association
Rehabilitation Institute of Metropolitan Detroit
All Rehabilitation Centers

* * *

Mr. Speaker, I move the adoption of Resolution No. 33,

[*The motion was duly seconded and carried.*]

XVII—7e. RESOLUTION NO. 34

The only change is in the second line of the first "Resolved" where after "compiling and development of," we added the word "additional" information. That is the only change in No. 34.

[The first "Resolved" of Resolution No. 34 was amended to read as follows]:

"RESOLVED: That the Presidents Program of the Michigan State Medical Society include the compiling and development of additional information related to the aged; advance the 10-point program of Help of the Aged, and such other additions to the program as may be subsequently determined in this swiftly changing situation, and be it further—"

Mr. Speaker, I move the adoption of Resolution No. 34.

[*The motion was duly seconded and carried.*]

XVII—7e. RESOLUTION NO. 35

In the first line of the third "Whereas" after "in Michigan have," we inserted the word "already" solved these problems; and in the next line, at the end of the line, we struck out the words "are not" and substituted "may not be generally known."

[The third "Whereas" of Resolution No. 35 was amended to read as follows]:

"Whereas, various areas in Michigan have already solved these problems in exemplary manner but knowledge of the many effective ways and means of doing so may not be generally known; therefore be it—"

* * *

With these amendments to this resolution, Mr. Speaker, I move the adoption of Resolution No. 35.

[*The motion was supported and carried.*]

XVII—7e. RESOLUTION NO. 36

This resolution was adopted by the committee unchanged.

I move the adoption of Resolution No. 36.

[*The motion was supported and carried.*]

XVII—7e. RESOLUTION NO. 37

This resolution was adopted by the committee unchanged. I move the adoption of Resolution No. 37.

[*The motion was duly seconded and carried.*]

XVII—7e. RESOLUTION NO. 38

This resolution was unchanged by the committee. I move adoption of Resolution No. 38.

[*The motion was duly seconded and carried.*]

LAWRENCE A. DROLETT, M.D.: Mr. Speaker, I move that the House approve the adoption of Resolutions 25 to 38 in toto as amended, generally approving the Presidents Program.

[*The motion was supported, discussed, and carried.*]

[The House of Delegates recessed at 12:20 o'clock.]

TUESDAY MORNING SESSION

September 27, 1960

The fourth meeting of the House of Delegates convened at nine-five o'clock with J. J. Lightbody, The Speaker presiding.

XVII—8. REPORT OF REFERENCE COMMITTEE ON HYGIENE AND PUBLIC HEALTH

XVII—8a. RESOLUTION NO. 39 RE VISUAL SCREENING PROGRAMS

OTTO K. ENGELKE, M.D.: This committee after considerable discussion changed the "resolved" section, not in principal, but in detail, to read as follows:

"RESOLVED: That the Michigan State Medical Society approves preschool and school visual screening if properly conducted. It offers the services of its members in helping to plan such programs. It recommends that community-wide programs in this field obtain the approval of the county medical society and/or the local health department. Technicians certified by the Michigan State Department of Health or teachers trained by public health nurses or other personnel with similar qualifications be utilized for screening;

"That this action be made available to all county medical societies, all local health departments, all school boards, all school superintendents and principals (public, parochial and private), PTA officers, interested service clubs, and other interested organizations."

Mr. Speaker, I move the adoption of this report.

[*The motion was supported and carried.*]

OTTO K. ENGELKE, M.D.: Mr. Speaker, this was the only resolution presented to this committee. I therefore move the report as a whole.

[*The motion was supported and carried.*]

THE SPEAKER: Thank you, Dr. Engelke, and your whole committee.

XVII—9. REPORT OF REFERENCE COMMITTEE ON NATIONAL DEFENSE AND DISASTER PLANNING

XVII—9a. RESOLUTION NO. 50 DEALING WITH CIVIL DEFENSE

DONALD D. FINDLAYSON, M.D.: The committee recommends that the "Resolved" section be amended to read as follows:

"RESOLVED: That each and every component county society of the MSMS be urged to appoint immediately a Civil Defense Committee Chairman for 1961 and be urged to send said chairman to the AMA County Societies Conference on Civil Defense, November 4-5-6, 1960, Chicago, Illinois."

Mr. Speaker, I move the adoption of this report.

[*The motion was supported and carried.*]

THE SPEAKER: Thank you and your committee, Dr. Findlayson, for this report.

XVII—10. REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

XVII—10a. RESOLUTION NO. 5

FRANKLIN L. TROOST, M.D.: The committee recommends that the "RESOLVED" section be amended to read as follows:

"RESOLVED: That the Michigan State Medical Society seek funds to loan at a low interest rate to such physicians beginning private practice in Michigan, and be it further

"RESOLVED: That the House of Delegates recommend to The Council immediate implementation of this program."

(See amended second Resolved on Page 466.)

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded.*]

EDGAR E. MARTMER, M.D.: I move an amendment that the word "investigate" be substituted for the word "implement" in the second statement.

THE SPEAKER: The "Resolved" portion then reads:

"RESOLVED: That the House of Delegates recommend that The Council investigate the implementation of this program."

[*The amendment was seconded and carried.*]

We will now vote on the motion to adopt this resolution as amended. All those in favor say "aye"; opposed "no." The motion is carried.

XVII—10b. RESOLUTION NO. 15, RE NAME MSMS SECTION ON MEDICINE

Your Reference Committee recommends that this resolution be approved as introduced.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

XVII—10c. RESOLUTION NO. 16 CONCERNING TRANSFER OF MEMBERSHIP

This resolution was thought by your reference committee to be too all inclusive in that it had state and national transfers, proration of dues all mixed in one resolution, and the committee felt that if these subjects were to be taken up, they should be taken up in separate parts. Therefore, Mr. Speaker, your committee recommends disapproval of Resolution No. 16.

[*The motion was duly seconded.*]

JOHN G. SLEVIN, M.D.: With regard to this matter of uniform transfer, may I point out this, that it has happened in the Wayne County Medical Society. A man from New York State transferred to Wayne County. He paid his dues in his previous county society for the whole year, came to Michigan, and while his dues were prorated as far as Wayne County was concerned, he could get no refund from his previous county society. Inquiry by him to the American Medical Association indicated that they had this question under study, but also, it was indicated it would have to come before the House of Delegates of the American Medical Association, and then it would have to come through the various delegates from each state.

It would seem only proper that the American Medical Association set up a uniform procedure for transfer. Although it is true that the action of the American Medical Association in this matter can only be advisory, nevertheless, a uniform procedure would seem very much in order. I speak, therefore, against the motion. In other words, in favor of passage of this resolution, rather than its defeat.

CLARENCE I. OWEN, M.D.: I think this would be a very appropriate resolution to take to the AMA. It is a problem, and it is not only a problem in Wayne County and in the State of Michigan. It is a problem all over the country where transfer membership occurs. It would be very appropriate, indeed, to take this, and I speak against the recommendation of the reference committee.

All those in favor of the motion to disapprove Resolution No. 16 say "aye"; opposed "no." The motion is lost. The resolution is now up to the House.

JOHN G. SLEVIN, M.D.: Mr. Speaker, I move the adoption of the resolution.

[*The motion was supported and carried.*]

XVII—10d. RESOLUTION NO. 24 RE EMPLOYEE RECOGNITION

DR. TROOST: The committee was unanimously in sympathy and believed what was called for in this resolution was well, but after consulting with Dr. McGillicuddy, Chairman of the Finance Committee of The Council and Dr. Mason also of The Council, at our meeting, each of these gentlemen assured us that we had no money available, and despite the fact that we heard last night there had been no economy moves heard around the Society, here is one.

It was estimated the cost of gifts for the first year would be about $1,200.00 in addition to the cost of the insignia, whatever they might cost. Therefore, your committee recommends disapproval of Resolution No. 24.

[*The motion was supported.*]

THE SPEAKER: The motion is to disapprove Resolution No. 24. This has been seconded.

RICHARD E. WUNSCH, M.D.: Mr. Chairman, I would like to discuss this. It seems to me that our employes at the State Society are of quite a bit of importance to us. They are doing a good job. Last night we went through rather rapidly approval of a large number of resolutions that will cost the Society a rather large amount of money—not that I am against them, but I think it is rather short sighted action on our part for the Society to economize on some recognition of a fine employe who is doing a good job for us.

I would like to speak in favor of the resolution.

WILLIAM J. YOTT, M.D.: Mr. Chairman, I happen to have been a member of this committee, and I believe that some of our decisions must be defended. We were told definitely that there was no money available. We are in sympathy of the originators of this resolution. We would like to be able to give something we don't have, but we don't have it.

We were told definitely that we did not have the money. The fact, the cost of having the insignias manufactured, or whatever they have to do to make them available, we were even told that they didn't have the money for that.

Now, if someone would like to donate the money, maybe the committee will be glad to go along with them.

ROSS V. TAYLOR, M.D.: I would like to ask for information, whether the State Society or whether The Council has a personnel committee to periodically review personnel policies of the Society. Employes are worthy of what they do, and rather than a periodic honorarium of some sort, I believe the recognition should be continuous. Does the Society have such a personnel policy?

D. BRUCE WILEY, M.D.: Thank you, Mr. Speaker. As you know, the Big Look Committee was originally formed for the idea of reviewing the personnel of the Michigan State Medical Society, and with a look to the future. They have studied the personnel of the executive office from time to time. However, this past year there also has been inaugurated an Advisory Committee to the Executive Director which meets each month with the executive director, going over the program that has been in operation, the activities of the staff, so that the matter of working in the activities of the personnel are reviewed each month and The Council is kept up to date with their activities.

RALPH A. JOHNSON, M.D.: Mr. Speaker, I would call to the attention of the House, the very important report that was made by Dr. Engelke. In that report you will find recorded many hours of diligent and extra service on the part of the staff in Lansing office. It is my very firm conviction that this House owes some form of recognition to that staff, and if it is the paltry sum of $1,200.00, it seems to me in view of the many other expenditures that we have, that this is a well merited program and should be endorsed.

LOUIS F. HAYES, M.D.: Mr. Speaker, in the same report Dr. Johnson referred to, I think you will all recall that in the discussion of the employes it was categorically stated that they were paid a fair amount less than similar type of employes throughout the country and I think this should be borne in mind. I would like to recommend to the House that if our situation is so dire that we cannot squeeze this lemon for $1,200.00, that rather than approve the Reference Committee's action to disapprove this resolution and cast this stigma, that we don't think these employes are worthy, I think it would be wise for us to take no action at this time and bring it up again next year.

EDGAR E. MARTMER, M.D.: Mr. Speaker, if I am correct, the function of the House of Delegates is primarily as a legislative body. The executive functions of the Michigan State Medical Society are the prerogatives and duties of The Council. The question of compensation of employes is primarily an administrative matter, and basically it is a matter which is the responsibility of The Council.

If that be true, then it would seem that included in the budget for salaries for employes, the matter under discussion should well be included. It is a matter for Council to decide, and that if there be a budget committee of The Council, when the budget for the year is prepared, matters such as these would be included. Therefore, since it is primarily an executive function, I would move that no action be taken on this motion, and that it be the sense of this body that it be considered by The Council, and if it is their feeling that it is proper, that they so conduct themselves.

THE SPEAKER: The motion is that no action be taken on this resolution.

SHERMAN L. LOUPEE, M.D.: Support.

THE SPEAKER: It has been supported. The motion is, no action be taken on this, and that it be referred to The Council.

DON W. MCLEAN, M.D.: There is one thought I would like to bring before the House at this time, and that is we are greatly concerned about public relations. We are spending a great deal of money on that item, and the one thing I think we should all bear in mind is that the best public relations begin at home. *(Applause)*

All those in favor say "aye"; opposed "no." The motion that no action be taken is lost. We will now consider the motion to disapprove Resolution No. 24.

CLARENCE I. OWEN, M.D.: Mr. Chairman, I agree with Dr. McLean that public relations begin at home. This is a mere pittance next to thousands and thousands of dollars we are spending on other things that we don't even want to bother about being a little economical. To turn this down would be most uneconomical. To recognize a group of valuable employes is a good thing to do. I speak against the present recommendation.

THE SPEAKER: All those in favor say "aye"; opposed "no." The motion is lost.

CLARENCE I. OWEN, M.D.: I move the adoption of this resolution.

THE SPEAKER: It has been moved and seconded that Resolution No. 24 be adopted.

All those in favor of adopting Resolution No. 24 say "aye"; opposed "no." The motion is carried.

XVII—10e. RESOLUTION NO. 40 RE INSURANCE REPORT FORMS

DR. TROOST: The original resolve read:

"RESOLVED: That the Michigan State Medical Society make available approved health insurance council form for physician reports to all members of the Michigan State Medical Society."

In the interest of economy, gentlemen, it was felt well that the Society should not be asked to bear the burden of printing, furnishing, distributing the insurance forms. We could picture $500,000 or a million a year that the Society would have to furnish us. We did not think it should be called upon to spend that money because of financial situation. Therefore, the resolved was changed to read:

"RESOLVED: That the Michigan State Medical Society approve the Health Insurance Council Forms for Physicians' Reports."

MR. SPEAKER, I move the adoption of this portion of the report.

[*The motion was duly seconded.*]

THE SPEAKER: It has been moved to adopt Resolution No. 40 as amended.

ARTHUR W. STROM, M.D.: I move to amend with the addition of the following words:

"And make available to all members of the Michigan State Medical Society the printers and sellers of these forms."

[*The amendment was duly seconded.*]

JOHN J. COURY, M.D.: In clarification, we went into this common insurance form in our county. The major carriers do approve or recommend a standard form that they could devise along with the American Medical Association. We attempted to carry out the use of a common insurance form in our county, but unless we can get the support of not only our county society and our state society, we might as well junk the whole idea because the other companies will refuse to accept any common form. I think if we are going to accept this, then we have to have the backing of the state body to see that all these companies will accept this form.

We carried it on for approximately a year until we got so many complaints from our patients that we ended up having to stop it because certain companies would refuse to accept these forms, and this was a form that was recommended by the major carriers as well as the AMA. Without your support, we might as well not do it.

THE SPEAKER: All those in favor of the amendment say "aye"; opposed "no." The amendment is carried.

The "resolved" portion of the resolution has been amended and now reads:

"RESOLVED: That the Michigan State Medical Society approve the Health Insurance Council Forms for Physicians' Reports and make available to all members of the Michigan State Medical Society the names of the publishers and sellers of these forms."

All those in favor say "aye"; opposed "no." The motion is carried.

FRANKLIN L. TROOST, M.D.: Mr. Speaker, I move the adoption of the entire report.

[*The motion was supported and carried.*]

THE SPEAKER: Thank you, Dr. Troost and all the members of your committee for this very fine report.

XII—56. HOUSE OF DELEGATES RESOLUTIONS

Introduced by RALPH R. COOPER, M.D. [Wayne]:

Whereas, this year many resolutions were introduced before the Annual Session and presented in printed form, and

Whereas, Chapter 9, Section 10 of the Bylaws requires that such resolutions should be presented to the Secretary in triplicate immediately after reading, and

Whereas, the same has not been done this year, therefore be it

RESOLVED: That Section M, Chapter 10 of the Bylaws be changed to read:

"Each resolution that is presented to the House of Delegates before the Annual Session will be presented at the first meeting in printed form. Any resolution introduced as new business after the start of the Session shall be introduced in writing and presented in triplicate to the Secretary immediately after the delegate has read the same. Each resolution shall be referred to the proper reference committee by the speaker before action is taken."

THE SPEAKER: This resolution will be referred to the Committee on Constitution and Bylaws.

XII—57. TECHNICAL AND ECONOMIC ADVICE

Whereas, the physicians of the State of Michigan are not professionally qualified to interpret statistical material and

Whereas, proper technical and economic advice in developing new contracts is essential and

Whereas, technical assistance and economic advice from Michigan Medical Service on vested interest of membership of the Michigan State Medical Society cannot be freely received without review, therefore be it

RESOLVED: That the Michigan State Medical Society engage technical and economic advice from private sources in the development of all future contracts or major changes of prepaid medical insurance.

THE SPEAKER: This resolution will be referred to the Committee on Resolutions.

[The House recessed at ten-five o'clock.]

TUESDAY EVENING SESSION
September 27, 1960

The Fifth Meeting of the House of Delegates reconvened at 8:10 o'clock with J. J. Lightbody, M.D., the Speaker, presiding.

Michigan's Foremost Family Physician

THE SPEAKER: Dr. Thirlby, it gives me a great deal of pleasure to announce to you that you have been elected Michigan's Foremost Family Physician by this House of Delegates. It gives me also a great deal of pleasure to present this scroll in recognition of that particular honor.

EDWIN L. THIRLBY, M.D.: All I can say is that my life has been one full of surprises, and I knew nothing about this. I didn't know what was coming until we had a meeting of our Medical Society a couple of weeks ago. Something was brought up. They tipped me off that this was it. It took me off my feet.

I do consider this the greatest honor that I have ever had.

I am trying to think of something else to say. I had a story I was going to tell, but it has gone. Dr. Frederick Coller always tells stories, and I have heard his so many times that I am afraid if I told one to you, you would recognize it.

I want to thank you all very much for this high honor. *(Applause)*

THE SPEAKER: Congratulations, again, Dr. Thirlby.

XVII—11. REPORT OF REFERENCE COMMITTEE ON RESOLUTIONS

XVII—11a. RESOLUTION NO. 1 RE MEDICAL CARE STUDY COMMITTEE

MILTON R. WEED, M.D.: In the opinion of the committee, this resolution may prove to be one of the most important presented to this House of Delegates. Its purpose is to provide the Society with accurate knowledge of social, political and economic trends upon which sound, farsighted decisions may be based avoiding thereby the hazards of action taken to meet recurring crises.

Without changing the intent of the resolution, but with a view to orderly implementation, the committee reworded it to read as follows:

Amended Resolution No. 1 on Medical Care Study Committee:

Whereas, twenty years ago, the Michigan State Medical Society embarked on a social experiment of prepared insurance for medical services for low income groups, and

Whereas, such insurance has been expanded to cover a large part of the population, and

Whereas, there is constant change in the social and economic conditions which have a bearing on medical care, and

Whereas, such changes can be predicted in advance to some extent, and

Whereas, it is important that the medical profession have a long-term knowledge of such future trends, therefore be it

"RESOLVED: That a committee of six members of the Michigan State Medical Society be appointed by the President to prepare a plan for long-range study of social, political and economic trends likely to affect future medical care in Michigan. This committee shall report its recommendations as to direction, scope and costs of such a continuing study at the next annual meeting of the House of Delegates, and be it further

RESOLVED: That a committee then be appointed to carry out the intent of this resolution by methods and procedures recommended in the study committee report and approved by the Michigan State Medical Society House of Delegates.

The committee recommends approval of this resolution as reworded. Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

XVII—11b. RESOLUTION NO. 17 RE THE APPOINTMENT OF A HISTORIAN FOR THE MICHIGAN STATE MEDICAL SOCIETY

DR. WEED: This resolution was approved by the committee with slight changes in wording to read as follows:

Whereas, it is of interest and value to future generations to have an available historical record of an organization, therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society direct The Council to appoint a Historian. The term of office for the Historian shall be three years without restriction on reappointment.

Mr. Speaker, I move adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

XVII—11c. RESOLUTION NO. 19 RE MSMS COUNCILORS HOLDING TWO POSITIONS

DR. WEED: This resolution dealt with problems arising from simultaneous membership on The Council of the Michigan State Medical Society and on the Board of Directors of Michigan Medical Service. The advantages and disadvantages inherent in implementation of this resolution were discussed at length.

The committee reworded the resolution as follows:

Whereas, it may not be to the best interest of either organization when a member of The Council of the Michigan State Medical Society is also a member of the Board of Directors of Michigan Medical Service, nevertheless certain advantages when close liaison exists between these two organizations, therefore be it

RESOLVED: That not more than two members of The Council of the Michigan State Medical Society hold simultaneous membership on the Board of Directors of Michigan Medical Service.

The committee recommends approval of this resolution as reworded. Mr. Speaker, I move adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

XVII—11d. RESOLUTION NO. 42 RE GENERAL PRACTICE RESIDENCIES

DR. WEED: This resolution is concerned with the present pilot program of the American Medical Association for development of general practice residencies. Dr. Rhoades and Dr. Hubbard gave valuable aid to the committee in its deliberations. While this committee is in sympathy with the intent of this resolution, it is the recommendation of the committee that it be disapproved for the following reasons:

1. The pilot program is at present only three months old. This is too short a time for adequate evaluation.
2. The present pilot program was approved before its inception by the American Academy of General Practice.
3. The channels of communications suggested in the resolution, namely through this House of Delegates of the American Medical Association are unnecessary as the American Academy of General Practice has direct communication and liaison with the proper committees and counsels of the American Medical Association.

Mr. Speaker, I move adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

XVII—11e. RESOLUTION NO. 43 STUDY COMMITTEE RE INDIGENT PHYSICIANS

DR. WEED: This resolution concerns the formation of a study committee to evaluate the problem of indigent physicians. It was approved by the committee with minor changing in wording. As reworded, it reads:

Amended Resolution No. 43 Study Committee re Indigent M.D.'s:

Whereas, there exist in this state indigent physicians and physicians' families and

Whereas, we are convinced that this situation is not the desire of this State Society, therefore be it

RESOLVED: That the Speaker of the House be directed to form a committee to study this problem and that this committee report its findings and recommendations to the next annual session.

The committee recommends approval of this resolution as reworded.

Mr. Speaker, I move adoption of this portion of the report.

FRANKLIN L. TROOST, M.D.: I would like to amend the resolution to use the words "doctors of medicine" instead of "physician."

[*The motion was duly seconded and carried.*]

Now we will vote on Resolution No. 43 as amended.

[*The motion was duly supported and carried.*]

XVII—11f. RESOLUTION NO. 51 RE TASK FORCE

MILTON R. WEED, M.D.: Resolution No. 51 is concerned with the problem of counteracting misconceptions of medical problems presented at public meetings. The committee believes that proper handling of this important problem lies in the province of the Public Relations Committee. It recommends, therefore, that this resolution be disapproved and that the problem be referred to the Public Relations Committee of the Michigan State Medical Society for its consideration.

Mr. Speaker, I move adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

XVII—11g. RESOLUTION NO. 53 RE RESIDENCY TRAINING PROGRAMS

MILTON R. WEED, M.D.: Resolution No. 53 is concerned with the problem of accreditation of residency training programs in private hospitals without outpatient clinics. The committee approved this resolution with minor changes in wording of the "resolved." The "resolved" as reworded reads as follows:

"RESOLVED: That the delegates of the Michigan State Medical Society to the American Medical Association House of Delegates be instructed to present a resolution to the American Medical Association House of Delegates recommending that either an adequate outpatient department in a private hospital or an alternative and equivalent course of training be accepted as meeting the requirement for an approved residency training program."

The committee recommends approval of this resolution as reworded.

Mr. Speaker, I move adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

RALPH A. JOHNSON, M.D.: Mr. Speaker, before the report as a whole is adopted, I would like to make the suggestion on Resolution No. 53, in the wording of instructing the delegate to the AMA. My point is this, Mr. Speaker. It happens at times that your delegate to the American Medical Association may not introduce a resolution approved by their state society because of strategy. When you instruct your delegation you deprive them of strategic advantage. Having been a member from the Michigan State Medical Society to the AMA, I believe it is important that the word "instructed" be changed to the word "requested." It does not remove any of the strength of the resolution, but it does give some discriminatory action to your delegate to the American Medical Association, and I think that point is important to be recognized by this House.

THE VICE SPEAKER: Since we have acted on this already, Dr. Johnson, it will necessitate that you make a motion to reconsider this resolution. Do you do so?

RALPH A. JOHNSON, M.D.: In my opinion it is important enough to move for reconsideration on that.

THE VICE SPEAKER: Do you so move?

RALPH A. JOHNSON, M.D.: I do.

[*The motion was duly seconded.*]

THE VICE SPEAKER: It has been moved and seconded that we consider Resolution No. 53 for purposes of inserting a word. Is there any discussion?

All those in favor say "aye"; opposed "no." The "ayes" have it.

We will now reconsider Resolution No. 53, and you will amend it, Dr. Johnson.

RALPH A. JOHNSON, M.D.: Mr. Speaker, if I may amend Resolution No. 53 to delete the words "instruct the delegate to the American Medical Association," and substitute the word "request."

THE VICE SPEAKER: Is there support to this amendment?

[*The amendment was supported.*]

THE VICE SPEAKER: Is there any discussion? Hearing none, all in favor say "aye;" opposed "no." It is carried.

Unfortunately, I think we have to revote on the resolution as a whole for approval of this resolution, and I will entertain a motion for approval.

RALPH A. JOHNSON, M.D.: So move.

[*The motion was duly seconded.*]

THE VICE SPEAKER: It has been moved and seconded that we approve Resolution 53 as reworded. All in favor say "aye;" opposed "no." It is carried.

XVII—11h. RESOLUTION NO 57 RE TECHNICAL AND ECONOMIC ADVICE

MILTON R. WEED, M.D.: Resolution No. 57 is concerned with a mechanism by which the House of Delegates may evaluate actuarial reports of Michigan Medical Service. The committee recommends disapproval of this resolution for the following reasons:

1. It would result in a duplication of effort.
2. It would result in unnecessary expenses to the Society for a service which is properly the function of the Board of Directors of Michigan Medical Service and of the Insurance Commissioner of the State of Michigan.
3. No evidence was presented to indicate that such a survey would yield more accurate information than that currently available.

Mr. Speaker, I move adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

MERLE A. HAANES, M.D.: The reason for this resolution, I was on the Medical Care Insurance Committee, The Council, for one year in which I closely observed the development of the $6500 contract and was confronted with a very complicated array of figures including unit values, percentages and so forth that we found it very difficult to understand. We had no place to turn to to ask for clarification of these figures, and as such we landed up with some unit values in fee schedules in the new contract that were lower than we had ten years ago. It was difficult to figure out how this happened. It became quite apparent there was a mechanism of certain percentage reduction which would be difficult to explain, but after thorough study, it was found this was a little out of order, and it was certainly more than it should have been.

In turning to the membership, or the technical assistance of Blue Shield, they did not feel it incumbent upon them to explain the technical aspects of the development of this because we had to accept it at face value.

Now I feel that the physicians in the State of Michigan should have technical and economic advice regarding their vested interest under special circumstances, not at all times, but certainly when it comes to accepting at face value, unit values, actuarial studies and so forth, more for their interpretation than their actual redevelopment and redoing, I am not stating the figures are wrong. The figures are right, but figures are terribly confusing, and they can be seen in different lights under different circumstances.

Now The Council itself recognizes the importance of having economic advice, and whether the mechanism is through the House of Delegates or employment through The Council, I think the principle of the doctors of medicine having technical and economic advisors much as they would have legal counsel and help in other professional fields, in which they are not proficient, certainly would be of significance in years to come.

THE VICE SPEAKER: I call for the question. You are now voting on disapproval of this resolution No. 57. All in favor say "aye"; opposed "no." It is disapproved.

MILTON A. WEED, M.D.: Mr. Speaker, I move the adoption of the report as a whole as amended.

[*The motion was supported and carried and the committee was thanked for an excellent job.*]

XIX. GENERAL MEETING OF THE MICHIGAN STATE MEDICAL SOCIETY

THE SPEAKER: Dr. Milton Darling come forward, please.

[Milton A. Darling, M.D., President of the Michigan State Medical Society, came forward and the audience arose and applauded.]

XIX—1. INDUCTION OF PRESIDENT KENNETH H. JOHNSON, M.D.

PRESIDENT MILTON A. DARLING: Thank you, gentlemen. Tonight constitutes a departure of the regular proceedings of the Michigan State Medical Society from years past. For obvious reasons, the transfers of the duties of the office of President are occurring before the House of Delegates.

At this time I would like to ask The Speaker of the House, Dr. Lightbody, and the Chairman of the Council, Dr. Meier, to kindly conduct the President-elect to the rostrum.

[J. J. Lightbody, M.D., and H. J. Meier, M.D., conducted Kenneth H. Johnson, M.D., to the platform and the assembly arose and applauded.]

PRESIDENT DARLING: Dr. Johnson, by virtue of your long and distinguished career in the service of your community, of your family and of your patients, and more particularly for the Michigan State Medical Society, the members of that Society have chosen you to become its President. In doing so they are conferring upon you the highest honor they have to offer.

By virtue of my position, it is my duty to transfer the office to you, and in doing so, I wish to place upon you the badge of your authority which represents the Michigan State Medical Society which you preserve, protect and defend throughout your term of office.

Here is the gavel which represents your emblem of authority. In all probability you will have no occasion to use it. *(Laughter)* But should the occasion arise, I pray your aim is unerring, and last but not least, I have the honor to place upon you this, and I remove this.

Ladies and gentlemen, the President of the Michigan State Medical Society, Dr. Kenneth H. Johnson.

[The assembly arose and applauded.]

XIX—2. REMARKS OF PRESIDENT KENNETH H. JOHNSON, M.D.

Mr. President, Mr. Speakers and Members of this House:

Gentlemen, I can only say that I am deeply touched and deeply flattered. I have been, as you know, connected with this House for several years. I can only wish with all my heart that every single member of the over 6000 doctors of medicine that we have in this Society could be present at your deliberations. I cannot conceive in my own mind of a more distinguished group.

I think that you are conducting the business of this Society in a way in which everyone of you should be proud. Thank you, Dr. Darling, Mr. Speaker, Mr. Vice Speaker, and all you members. *(Applause)*

XIX—3. PRESENTATION OF SCROLL AND KEY TO PAST-PRESIDENT MILTON A. DARLING, M.D.

DR. JOHNSON: It is my distinct privilege, and I mean this from the bottom of my heart, to present to Dr. Darling a scroll for his service as President of this Society. I know of no one who has done a better job in all the years that I have been connected with this Society, and Milton, it is my very great pleasure to present you this scroll which states:

"Presented by the Michigan State Medical Society to Milton Darling, M.D., President 1959-1960, in deep appreciation and grateful recognition of distinguished service rendered to medicine."

It is signed by the Chairman of the Council, H. J. Meier, M.D., and by the Secretary, D. Bruce Wiley, Detroit, Mich., September 27, 1960.

And along with it, Dr. Darling, is the Past President's key.

[The key and scroll were presented to Milton Darling, M.D.]

PAST PRESIDENT MILTON DARLING: Thank you, very much, sir. It is a distinct honor and a pleasure which I shall cherish always. Thank you very kindly.

[The assembly arose and applauded as Milton Darling, M.D., and Kenneth Johnson, M.D., retired from the platform.]

JACK ROM, M.D. [Wayne]: Mr. Chairman, may I move the recognition given by The Council to Dr. Darling be reaffirmed by the House of Delegates.

[*The motion was supported.*]

THE SPEAKER: You have heard the motion properly seconded. All those in favor say "aye"; opposed "no." Thank you.

House of Delegates Reconvenes

THE SPEAKER: We will now reconvene as the House of Delegates. We will proceed with supplemental reports of Reference Committees.

XVIII. SUPPLEMENTAL REPORTS OF REFERENCE COMMITTEES

XVIII—1. REFERENCE COMMITTEE ON REPORTS OF THE COUNCIL

JAMES B. BLODGETT, M.D.: Mr. Speaker, there are several recommendations of The Council that were put aside last night for later action.

The Council's recommendation No. 1 that was held over was that the House of Delegates give approval to the President's Program and urge enthusiastic support of this important project by all members.

I move the approval of this recommendation.

[*The motion was supported and carried.*]

JAMES B. BLODGETT, M.D.: Another such recommendation was No. 6, that the House of Delegates approve amendment to the Bylaws (Chapter 10, Section 1) to confirm the traditional practice of electing the officers of The Council in September, immediately after the election of new Councilors by the House of Delegates.

Mr. Speaker, I move the approval of this recommendation.

[*The motion was supported and carried.*]

JAMES B. BLODGETT, M.D.: Another such recommendation, No. 7, that the House of Delegates reactivate the MSMS Cancer Control Committee by approving amendment to Bylaws (Chapter 11, Section 3), as the guidance and advice of this committee is necessary at this time.

Mr. Speaker, I move the adoption of this recommendation.

[*The motion was duly seconded and carried.*]

JAMES B. BLODGETT, M.D.: The final such recommendation is No. 10, that the House of Delegates favorably consider a resolution establishing a system of awards for the employed personnel of the Michigan State Medical Society based upon length of time in satisfactory service and providing proper recognition in the form of insignia and other emoluments.

I move the adoption of this recommendation.

[*The motion was duly seconded and carried.*]

JAMES B. BLODGETT, M.D.: Mr. Speaker, I move the adoption of this report in toto.

[*The motion was duly seconded and carried.*]

THE SPEAKER: Thank you, Dr. Blodgett, and thanks to the members of your committee for this very fine report.

XVIII—2. SUPPLEMENTAL REPORT OF REFERENCE COMMITTEE ON REPORTS OF SPECIAL COMMITTEES

XVIII—2a. SUPPLEMENTAL REPORT ON COMMITTEE TO STUDY MSMS FINANCIAL STRUCTURE

KEATE T. MCGUNEGLE, M.D.: The report of the committee so ably headed by Dr. Engelke contained a recommendation not included in yesterday's report of your reference committee because it was felt that this suggestion was important enough to require a separate recommendation.

It read, "We recommend the study of the establishment of a 'ways and means' type of reference committee of the House of Delegates to appraise the costs of new or special House of Delegates projects before they are voted by the House."

Your reference committee enthusiastically endorses the principle contained in this recommendation. It is quite obvious the majority of this House is strongly of this mind also.

After a long discussion, your committee felt that such a ways and means committee should be charged with the duty of furnishing cost estimates to the House on all motions involving expenditures of funds prior to final action by the House of Delegates.

Therefore we recommend **that the Speaker appoint and implement such a reference committee to be inaugurated in the next session of the House of Delegates under the authority of Chapter 9, Section 10, Subsection E of the Bylaws.**

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

XVIII—2b. ANNUAL REPORT OF HOUSE OF DELEGATES COMMITTEE ON COMMITTEES

DR. MCGUNEGLE: Each year since 1957 there has been a committee to study the the committee structure with a view to streamlining it. This year's Committee on Committees consisted of Drs. Johnson, Wiley, Fisher, McIntyre, myself, and George Slevin as chairman. The five basic categories of committees of the MSMS were used as the basic working draft. Your committee respectfully makes the following recommendations:

1. That each Standing Committee of the Michigan State Medical Society, appointed by the President, and each Standing Committee of The Council have a Vice Chairman appointed thereto. Purpose: To train future committee chairmen and to have available a qualified committee member to assume the duty of the chairman in his absence or incapacity.

Mr. Speaker, I move the adoption of this portion of the report.

THE SPEAKER: Is there a second to the motion to adopt?

[*The motion was duly seconded and carried.*]

K. T. MCGUNEGLE, M.D.: Recommendation No. 2 of the Committee on Committees. That the Chairman of The Council be urged to utilize existing and proper committees as presently designated before ad hoc or special committees are appointed.

Recommendation No. 3. That the appointing officer (President in the case of Michigan State Medical Society Committees and Council Chairman in the case of Council Committees) abolish any special committee not active for one year.

Mr. Speaker, I urge the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

K. T. MCGUNEGLE, M.D.: Recommendation No. 4. That the purpose of each and every committee now existing or to be appointed in the future, be completely spelled out, to avoid reduplication and to make for better understanding and efficiency of operation.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

K. T. MCGUNEGLE, M.D.: Recommendation No. 5. That the House of Delegates give consideration to limiting the terms of all committee chairmen of The Council (appointed by The Council or The Council Chairman) and of the Michigan State Medical Society (appointed by the President) to a certain number of years as three or four years in order to gain more worked for and interest in the Michigan State Medical Society.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was supported and carried.*]

K. T. MCGUNEGLE, M.D.: The next recommendation is that the 41 committees of The Council be reduced to five standing and eight special committees as follows, with the President and Secretary being ex officio members of all committtees:

A. 1. That the following amendment be added to the Bylaws. Chapter 10, new Section 2: (a) That "the County Societies Committee shall consist of a Chairman elected by The Council as indicated in Chapter 10, Section 1, and five members appointed by The Council Chairmen with the advice of The Council."

Mr. Chairman, I recommend the adoption of this portion of the report.

RALPH R. COOPER, M.D.: Mr. Speaker, I believe that since this is a Bylaw change, it is required that this be laid over for one meeting.

THE SPEAKER: The chair will rule that this will be put off until the next meeting.

K. T. MCGUNEGLE, M.D.: In that case, the following are all proposed additions to the Bylaws:

2. That Chapter 10, New Section 2 (b) be added to the Bylaws:

"Finance Committee: The Finance Committee shall consist of a Chairman elected by The Council as indicated in Chapter 10, Section 1, and six members, five to be appointed by The Council, and the Treasurer of the Michigan State Medical Society who is to be an ex officio member with power to vote. The Finance Committee shall advise The Council on administration of the Society's finances, and shall submit reports to The Council at least three times a year, including an Annual Report."

3. That Chapter 10, New Section 2 (c) be added to the Bylaws:

"Publication Committee: The Publication Committee shall consist of a Chairman elected by The Council as indicated in Chapter 10, Section 1 of the Bylaws, and six members, five of whom are to be appointed by The Council Chairman with the advice of The Council and the Editor of The Journal of the Michigan State Medical Society who will serve ex officio without power to vote. The Publication Committee shall be the Editorial Board of The Journal of the Michigan State Medical Society and shall advise The Council and the Editor in the conduct and policy of The Journal of Michigan State Medical Society, and shall submit reports to The Council at least three times a year including an Annual Report."

4. That the following amendment be added to the Bylaws, Chapter 10, New Section 2. (d) The Committee of Past Presidents:

Past Presidents: "The Committee of Past Presidents shall consist of all living Past Presidents of the Society who shall select their own Chairman, Vice Chairman and Secretary and shall meet at least once per annum.

This committee shall advise The Council on matters of public policy and aid The Council in projects pertaining to the general good of the State Society. It shall submit an Annual Report to The Council."

Education Liaison Committee.

5. This committee recommends a new Standing Committee of The Council to be known as "Education Liaison Committee" and recommends that Chapter 10, New Section 2 (e) of the Bylaws be added accordingly as follows: "The Education Liaison Committee shall consist of a Chairman, a Vice Chairman and not more than five additional members to be appointed by The Council Chairman with the advice of The Council. The Deans of the Medical Schools of Michigan and the Secretary of the Michigan State Board of Registration in Medicine shall be advisory members of this committee without vote. The Education Liaison Committee shall advise The Council on all matters pertaining to undergraduate medical education, licensure with the Michigan State Board of Registration in Medicine, and shall set up and coordinate courses for the Medical Schools dealing with Medical Economics and Medical Ethics."

That is likewise a proposed change in the Bylaws.

B. The committee further recommended that the following committees be made Special Committees of The Council and their duties spelled out:

1. Liaison Committee with Michigan Veterans Organizations.

2. Liaison Committee with the Health Insurance Council.

3. Michigan State Medical Service Representatives to the Michigan Cancer Coordinating Committee.

4. Michigan State Medical Society Representatives to Permanent Conference Committee.

5. Committee on Awards.

6. This paragraph was deleted by the Reference Committee for the reason there were other resolutions on the floor of the House which were either in opposition or complemented the idea behind this proposal. Therefore, it was deleted.

7. Liaison Committee with the State Bar of Michigan.

8. National Disaster and Civil Defense Committee.

Mr. Speaker, I move the adoption of this portion of the report known as "B" (on Page 96 of Handbook).

THE SPEAKER: **The Chair will rule all items having to do with rules in the Bylaws will be put over for one meeting, whenever that meeting will be, and hereby refers these items to the Committee on Constitution and Bylaws in case we happen to have another meeting.**

The motion to adopt this portion of the report as amended except those portions having to do with the Bylaws. Is there any discussion?

MAX L. LICHTER, M.D. [Wayne]: Mr. Speaker, I would move an amendment to Item 8 that this committee be known as the "Committee on Disaster Medical Care" which will make its designation conform with the designation of the similar committee in the American Medical Association.

THE SPEAKER: Your motion is to change the name of the committee from "National Disaster and Civil Defense Committee" to "Committee on Disaster Medical Care."

[*The motion was supported and carried.*]

THE SPEAKER: We will now vote on the motion to approve this portion of the report as amended. All those in favor say "aye"; opposed "no." The motion was carried.

K. T. MCGUNEGLE, M.D.: Page 97 of Handbook re Postgraduate Medical Education Committee has already been acted on in substance in this session of the House.

Page 98 of Handbook: The committee recommends that the Standing Committee of Michigan State Medical Society known as Committee on Preventive Medicine and its Subcommittees be changed to "Public Health Committee" and that Chapter 11, Section 3 of the Bylaws be amended as follows:

Delete—"Rheumatic Fever Control" and substitute "Cardiac Disease Control."

This committee disapproves the next sentence. That is, deleting "Venereal Disease Control" and "Tuberculosis Control" and substituting "Communicable Disease Control."

The reference committee recommended disapproving that deletion.

Third deletion, "Postgraduate Medical Education," which is set up as separate committee.

Recommend that the following be made subcommittees of the Public Health Committee:

A. Committee on Rural Medical Service
B. Committee on Blood Banks
C. Highway Accident Prevention
D. Committee on Cancer Control
E. Committee on Diabetes Control
F. Committee on Iodized Salt
G. Venereal Disease Control
H. Tuberculosis Control

Moreover, the committee recommends that the work of the Liaison Committee with Michigan State Society of Neurology and Psychiatry and the Michigan Psychological Society be taken over by the Subcommittee on Mental Health.

The committee recommends that the Bylaws be amended by adding to Chapter 11, a New Section 8 to be known as "Advisory Committee to Woman's Auxiliary" as follows:

"Section 8. The Advisory Committee to the Woman's Auxiliary of the Michigan State Medical Society shall consist of a chairman and not more than three members. It shall be available to the Woman's Auxiliary for guidance in its activities and to advise concerning its problems. The Advisory Committee shall transmit to the Woman's Auxiliary any projects that the State Society feels should be undertaken by the Woman's Auxiliary for the benefit of the profession and the people served by the profession," and a new Section 9 to be known as Advisory Committee to the Michigan State Medical Assistants Society.

"Proposed Amendment to Bylaws, Chapter 11, new Section 9. The Advisory Committee to the Michigan State Medical Assistants Society shall consist of a chairman and not more than three members. It shall be available to the Michigan State Medical Assistants Society for guidance in its activities and to advise concerning its problems. The Advisory Committee shall transmit to the Michigan State Medical Assistants Society any projects that the State Society feels should be undertaken by MSMAS for the benefit of the profession and the people served by the profession."

The committee recommends that Chapter 11, Section 4 be amended by deleting the following: "The President shall appoint such Subcommittees of this Committee as are required in the execution of its work," and substituting therefor the following: "The President shall appoint the following Subcommittees (a) Radio and Television; (b) Press; (c) Scientific Motion Pictures; (d) Publications. Each of these Subcommittees shall consist of a Chairman and four members.

THE SPEAKER: Any portion of this report that has to do with change in the Bylaws will automatically be put off until the next meeting, and it will not be necessary to read them at this time.

The committee recommends a new Section 10 of Chapter 11 of the Bylaws be added as follows:

A Committee on Professional Insurance Plans shall consist of a Chairman and Vice Chairman and not more than six additional members. It shall be the duty of this committee to study such matters as professional liability insurance, group insurance, retirement plans, and the insurance plans pertaining to MSMS members. It shall

submit an annual report with recommendations to the House of Delegates.

The committee recommends that a New Section 3, Chapter 10 be added to the Bylaws as follows:

"Special and ad hoc committees may be appointed by The Council or its chairman with the advice of The Council, as required to help administer the executive functions of the Society, provided that no existing Stand-in or Special Committee is qualified to perform such duties. Each such committee shall render periodic reports of its findings and recommendations to The Council."

The Committee on Committees after careful review of the various House of Delegates Committees, noted that all but the Permanent Advisory Committee on Fees are ad hoc committees, with the Committee to Review the Financial Structure of Michigan State Medical Society being appointed every three years and, therefore no change in House of Delegates Committees is recommended.

The committee recommends that in Chapter 10 of the Bylaws, Section 2 through 12 be renumbered to 4 through 14 to accommodate the new section as recommended above; and to Chapter 11, Section 1 be added the subdivisions "g" and "h" and also the new Sections 8, 9 and 10 as recommended above.

The committee desires to thank the Executive Director and his staff for their task and the Reference Committee wish to commend the Committee on Committees for the work they have done.

Mr. Speaker, I move the adoption of that portion of the report.

THE SPEAKER: It has been moved to adopt this report as amended except those portions of the report having to do with the change in the Bylaws.

[*The motion was duly seconded and carried.*]

K. T. MCGUNEGLE, M.D.: Mr. Speaker, I move the adoption of the report of the Reference Committee on Reports of Special Committees as a whole as amended.

[*The motion was seconded and carried.*]

XVIII—3. SUPPLEMENTAL REPORT OF THE REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS

XVIII—3a. RESOLUTION NO. 56

RALPH R. COOPER, M.D.: After discussion, the resolved portion of this resolution was amended to read: "Each resolution shall be introduced by a delegate. It shall be in writing and presented in triplicate to the Secretary. It shall be referred to the proper Reference Committee by the Speaker before action thereon is taken.

Mr. Speaker, since this requires a Bylaw change no action can be taken until the next meeting.

THE SPEAKER: No action will be taken on this resolution until the next regular meeting.

RALPH R. COOPER, M.D.: At our supplemental meeting on Constitution and Bylaws last evening it was pointed out that several of our recommendations were Bylaw changes and should be laid over for one meeting. This has been accomplished, and we are now ready to consider again these portions which were laid over.

The report of the Special Committee to Study Election of Councilors on a Geographic Basis and Status of Councilors as voting members of the House of Delegates was considered together with Resolutions 12, 13 and 44 which had been proposed to implement the recommendations of the committee. Resolutions 11 and 12 are disapproved since The Council acts as the interim body. This was laid over from last year. This has been acted on.

It was felt, therefore, that confusion of responsibility would result if Councilors were elected by popular vote. It was also felt if the Councilors were not elected by popular vote they should not be granted a vote in the House of Delegates.

XVIII—3b. RESOLUTION NO. 13 MSMS COUNCILORS—TERM OF OFFICE

Was recommended by deleting the phrase "and provided further that not more than eight Councilor terms shall expire normally at any Annual Session."

Resolution No. 13 as amended was then approved.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

XVIII—3c. PETITION FOR REVOCATION OF CHARTER. RESOLUTION NO. 14 ON CLARIFICATION OF THE MSMS BYLAWS

Was approved as submitted. This was a motion on clarification, changing the wording. The present reading is: "Petition for the revocation of charter of any component county society may be filed with The Council by a Councilor of the district within which *each* society is located."

It was moved to be changed to :"Revocation of charter of any component county society may be filed with The Council by a Councilor of the district within which such society is located."

This was apparently a typographical error in the book, but we need action to change it back to the original form.

Mr. Speaker, I move to adopt this portion of the report.

[*The motion was seconded and carried.*]

XVIII—3d. RESOLUTION NO. 18 ON CONSISTENCY OF COUNTY—MSMS BYLAWS RE BYLAWS, CHAPTER I, Sec. 1.

This was previously presented and discussed. (See Page 393.)

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

RALPH R. COOPER, M.D.: Mr. Speaker, I move the adoption of this report as amended as a whole.

[*The motion was duly seconded and carried.*]

Thank you Dr. Cooper.

XVII—12. REPORT OF THE REFERENCE COMMITTEE ON RULES AND ORDER

XVII—12a. RESOLUTION NO. 54 RE REVISED RULES AND ORDER OF BUSINESS OF HOUSE OF DELEGATES

CLAUDE L. WESTON, M.D.: The subject of this resolution was on revising the rules and order of business for the Annual Session of the MSMS House of Delegates, and because of the nature of this subject it was considered advisable to divide the resolution into two sections.

The original resolution read: "That the Annual meetings of the MSMS House of Delegates consist of six meetings with the following order of business." Continuing, the first meeting was arranged for Sunday afternoon. This was to be the organizational meeting taking up the headings numbered 1 to 16 under the order of business as printed in the Handbook and as presently used. It was also outlined that the order of business for Sunday evening should include the reports of House Committees, Standing Committees, and Special Committees of MSMS, after which the introduction of resolutions was to be made. The agenda for the Monday and Tuesday meetings was also contained in the original resolution.

After thorough discussion by members of the committee and guests, which included B. M. Harris, M.D., Councilor, and D. Bruce Wiley, M.D., Secretary, it was felt that it lay within the province of the Speaker of the House to arrange extra or additional meetings of the

House, and that probably he being in close contact with the activities, would be in a better position to judge the necessity for such meetings.

Therefore the committee recommends a substitute "Resolved" which shall read as follows:

"Be it resolved that the number of meetings of the session of the MSMS House of Delegates be determined by the Speaker according to the volume of business to be considered."

Mr. Speaker, I move the adoption of this portion of the resolution.

[*The motion was duly seconded and carried.*]

CLAUDE L. WESTON, M.D.: The second portion of the resolution which has to do with the means of implementing the work of the delegates was very carefully considered and thoroughly discussed by all present. The committee recommends that this portion be adopted, with a few amendments and shall read as follows:

"Be it further resolved that to save time and to implement the work of the delegates

A. All preliminary reports of

1. The Council and Council Committees
2. The Delegates to the AMA
3. Michigan Medical Service
4. The House Committees
5. MSMS Standing and Special Committees be included in the loose-leaf notebook introduced at this session, such reports being completed as of the 31st of August, and

B. The above notebooks with complete reports be sent to delegates by the 20th of September.

C. That the present loose-leaf notebook also include the Constitution and Bylaws, committee membership and other miscellaneous information now included in the printed Handbook, and

D. That all of the above reports be accepted by the delegates in the printed form, with only explanatory remarks being made by the chairman from the podium."

Mr. Speaker, I move the adoption of this portion of the resolution as amended.

[*The motion was duly seconded and carried.*]

CLAUDE L. WESTON, M.D.: Mr. Speaker, I move the adoption of the report of the committee as a whole.

[*The motion was seconded and carried.*]

THE SPEAKER: Thank you, Dr. Weston and your committee for their work.

XVIII—4. SUPPLEMENTAL REPORT ON THE REFERENCE COMMITTEE ON LEGISLATION AND PUBLIC RELATIONS

LAWRENCE A. DROLETT, M.D.:

XVIII—4a. RESOLUTION NO. 52 RE MICHIGAN CRIPPLED CHILDREN COMMISSION FEE SCHEDULES

The "Resolved" reads:

"That the Legislature of the State of Michigan be requested to adjust the Michigan Crippled Children's Commission Fee Schedule for doctors of medicine to conform to the Michigan Uniform Fee Schedule for Governmental Welfare Agencies."

The committee adopted this resolution unchanged. Mr. Speaker, I move the adoption of the resolution.

[*The motion was seconded and carried.*]

XVIII—4b. RESOLUTION NO. 55 RE PEOPLE-TO-PEOPLE HEALTH FOUNDATION

DR. DROLETT: I believe this regards the ship Hope, and the "Resolved" is:

"That the Michigan State Medical Society endorses and commends the interest and objectives of the People-to-People Health Foundation and the work of the Michigan Physician's Committee for the People-to-People Health Foundation."

The committee unanimously recommends that this resolution be adopted. Mr. Speaker, I move the adoption of the resolution.

[*The motion was seconded and carried.*]

LAWRENCE A. DROLETT, M.D.: I would like to move the adoption of the entire committee report, and thank the members of my Committee on Legislation and Public Relations. They have done a very fine job.

[*The motion was duly seconded and carried.*]

Thank you very much, Dr. Drolett and your committee for their work.

XVII—13. REPORT OF THE REFERENCE COMMITTEE ON MEDICAL SERVICE AND PREPAYMENT INSURANCE

DONALD N. SWEENY, JR.: Mr. Speaker, your Reference Committee on Medical Service and Prepayment Insurance is prepared to present a complete report at this time.

First, I would like to thank the Speaker and those with whom he consulted for providing me, as Chairman of this Reference Committee, with Committeemen who are not only well versed in background material on prepayment problems but who were also untiring in their invaluable and wise assistance during our many committee meetings. I express my thanks to these men: Sidney Adler, M.D., James D. Fryfogle, M.D., Don Marshall, M.D., Robert L. Novy, M.D., John W. Rice, M.D., R. Wallace Teed, M.D. and John M. Wellman, M.D.

I would also like to express my appreciation to several other gentlemen who are present by invitation for information. They are: Doctor G. Thomas McKean, President of Michigan Medical Service, Mr. L. Gordon Goodrich and his staff of Michigan Medical Service, Dr. Donald H. Stubbs, Dr. Russell Carson, and Mr. John W. Castelucci of the National Blue Shield Association.

I would be remiss at this point if I failed to thank the members of Dr. D. Bruce Wiley's staff of this Society who cheerfully worked not only during the day but late last night typing, mimeographing and helping me with my spelling.

This Reference Committee was presented with four reports of committees and nine resolutions. This report will deal with each of these in order.

The reference committee in its open hearings allowed all interested members of this society and the several invited guests to participate in discussions.

The first item of business had to do with the MCIC Report.

XVII—13a. MEDICAL CARE INSURANCE COMMITTEE REPORT

The Reference Committee reviewed the supplemental report of the MCIC, dated September 18, 1960. We compliment the committee on the considerable work done during the year to understand the problem of the impact of a $6,500 family income contract upon subscribers, employers, and physicians.

We believe the unit value as recommended by the MCIC for the M-65 group of contracts was based on inadequate statistical information furnished. At the time the unit values for the M-75 series were being established by MSMS Committees, compensation for the difference between the projected annual rate of earnings of the subscriber and the gross annual earnings of the family were taken into consideration. This upward adjustment was necessary because of the amended base for the determination of service benefits. This was estimated to be 15% of the projected annual rate of earnings of the subscriber. This estimate is now thought to have been an arbitrary decision which was based on inaccurate information. We do not think that this is binding in the present determination of unit values for the M-65 contracts. Therefore, the Reference Committee recommends that the unit values of M-65 contracts be not approved.

Mr. Speaker, I move the adoption of this portion of the report.

THE SPEAKER: Is there a second to the motion?

[*The motion was duly seconded and carried.*]

DONALD E. SWEENY, JR., M.D.: We note the information obtained by the MCIC regarding the reaction of the public to the M-65 contract. We believe the information therein is of very considerable importance, as it reflects on the attitude of these groups towards the problem that has been under consideration. We encourage the concept that there should be continued conferences on specific problems of medical care between leaders in medicine and leaders in industry, business, and the labor fields, as illustrated by activities of this committee.

We considered the recommendations made by the MCIC (to be found on Page 11 of the MCIC Supplemental Annual Report.)

We revised recommendation No. 1—to read as:

No. 1: **"The M-75 contract be continued in its present form with changes to be made as necessary."** (Amended—see below.)

No. 2.: **"Further studies should be made of a basic contract with a low-income ceiling."**

No. 3. **"Blue Shield subscribers should be educated as to the costs of high utilization and how they are individually affected by these high costs."** This prospect belongs in the field of public relations and is not germane to the work of the MCIC.

We revised No. 4 to read: **Conferences on specific problems of medical care between leaders in medicine and leaders in industry, business, and the labor fields should be continuous.**

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded.*]

THE SPEAKER: You have heard the motion. It has been seconded.

MAX L. LICHTER, M.D.: I move that recommendation No. 1 be amended by the addition of the following: **The M-75 contract shall provide that where a participating physician has reason to believe that the combined earnings of a subscriber and working spouse are greater than the maximum income of the applicable contract then in force, the physician may at his discretion make a charge in excess of that provided in such contract unless the subscriber furnishes evidence that the combined income of subscriber and spouse is not in excess of the maximum income specified in his contract. Disputes shall be resolved by Michigan Medical Service whose decision shall be binding upon both parties.**

FLOYD B. LEVAGOOD, M.D.: I would like to support this, Mr. Speaker.

JOHN W. RICE, M.D.: This in essence takes the guarantee out of the single subscriber income. It puts it back on the family income basis, and gentlemen, if that is what you want to do and abrogate the contracts we have in force and abrogate the contracts that are based on the single subscriber income, then it is your pleasure.

MAX L. LICHTER, M.D.: One of the big problems that has bothered this House is the question of the working wife or the working spouse. This has created many situations of inequity in which one finds that a spouse with a minimum income and a minimum contract presents the identification card for the entire family even if the other spouse is employed at an average wage. This has required many physicians adhering to the service principle to furnish such people service at a fee less than a physician should receive.

Now the number of instances in which this occurs is admittedly small, but nonetheless, this is a very honorous situation. The intent of this amendment in no way removes certification. It still adheres to the single subscriber principle, but in those cases where it is obvious that the physician is not being adequately compensated it permits the physician to make a determination which will be fair to him.

RALPH R. COOPER, M.D.: I just want to point out when we are talking about abrogation of certain things in the contract, that the board of Blue Shield has already advocated things in this contract by reneging on the promise that these contracts should be sold only in the price class involved, that we all know there has been many instances in which the people earning over $7,500.00 have been allowed to buy class A, class B contracts at their wish, so the precedent for the abrogating certain small parts of this contract is already established, and I feel that I would support Dr. Lichter's amendment.

MERLE A. HAANES, M.D.: Mr. Chairman, I think the significant part in support of this is that it was almost impossible to accurately determine family income by Michigan Medical Service or by industry, and this was one of the things they most steadfastly did not want to take up. So last year we agreed that the doctor himself would assume this responsibility if and when he should undertake to determine family income.

Now the amendment places this in a very nice position whereby certification continues, and if the physician truly has reason to believe this income far outstrips the certification, it would give him the right to certify himself, family income, without having Blue Shield or any of our large corporations having to take this on, and I would recommend that this amendment be adopted.

FLOYD B. LEVAGOOD, M.D.: Mr. Chairman, I wish you would all listen to this amendment very carefully. If you remember, last year, there was a great deal of argument, a great deal of dissatisfaction on this very point. Dr. Rice knows full well what an argument arose on this point. This doesn't do anything except make it fair for many of these families, and it is fair to the physician. These are small in number, but this is an example of the type of thing that causes a split and creates disharmony in the profession on something that really doesn't matter to a great percentage, but it is something that will produce harmony where there is nothing but discord at the present time.

JOHN W. RICE, M.D.: As the man who made the amendment knows, and as he stated, this affects only a small number of people. Only 50% of the contracts based on factual evidence are issued to people who might come under a family income. The other 50% are in brackets that could not come under family income. They are either certificates, noncertified, single subscribers or not married, or there is one other group which I do not recall. I don't think this is coming up, but any way, of the other 50% there is only a small portion who are subject to the family income determination. If this amendment is adopted, gentlemen, as I said before, you abrogate your agreement with Blue Shield.

Blue Shield as you can guess is not in any authority to certify to their subscribers that this contract will be guaranteed and that the fee that is allowed you will be a total fee, and that you will guarantee service on that fee.

Now if you feel that you do not care to guarantee service on such a fee, then that is your pleasure. That is the entire basis of all the business that has been done by Blue Shield up to this point, and this little simple amendment abrogates this whole thing. I think you should be aware of that.

MAX L. LICHTER, M.D.: I would just like to point out to the previous speaker, my good friend Dr. Rice, that the intent of this amendment is not to abrogate. The intent is that this wording or wording like it shall become part of the contract.

I, as you know full well, would not be party to anything which would abrogate the responsibilities of this Society or of its members, and I would think that this would only have force if the contract language were so changed as to include this which I am sure you will concede then is no abrogation.

All those in favor of the amendment say "aye"; opposed "no." **The amendment is carried.**

We will now vote on the motion to adopt this portion

of the report which includes recommendations one to four.

All those in favor say "aye"; opposed "no". The motion is carried.

XVII—13b. REPORT OF THE JOINT COMMITTEE OF THE MICHIGAN STATE MEDICAL SOCIETY AND NATIONAL BLUE SHIELD ASSOCIATION

Dr. Sweeny: We take cognizance of the information as to the responsibilities of the Corporate Body and the Board of Directors of the Michigan Medical Service and the responsibilities that exist in the relationship of one to the other. The questions raised about the responsibilities and prerogatives of the Michigan State Medical Society as they encroached and negated the responsibilities of the Board of Directors of Michigan Medical Service was a direct result of the adoption of the Statement of Principles on Prepaid Medical Care Insurance, adopted September 25, 1957. These Principles of 1957 vested authority which is the legal responsibility of the Board of Directors of MMS in committees of The Council of the Michigan State Medical Society. Such conflict created confusion. **We approved of the recommendations as follows:**

I. That the original 1957 Statement of Principles be replaced by the "Revised Statement of Principles on Pre-paid Medical Care Insurance." stated in the report (commencing on page 6) to be amended as follows:

The Michigan State Medical Society will approve voluntary, non-profit, prepayment medical benefit plans which:

1. Make generally available voluntary, non-profit, prepayment plans in Michigan which will permit the financing of the costs of medical services.

2. Provide for the people of Michigan, represented by the subscribers, a method of helping them to meet the costs of medical care by providing payment to physicians for these services.

3. Support the best standards of medical practice by a professionally qualified, independent medical profession.

4. Endorse the service principle of medical care at an income level approved by the House of Delegates of the Michigan State Medical Society.

5. Maintain the principle of freedom of choice for both the physician and the patient.

And further, the Michigan State Medical Society shall:

a) Cause periodic studies to be made of economic conditions as they relate to service income levels and accompanying schedules of benefits. It shall make periodic reviews of the fee schedules.

b) Provide a mechanism to examine and consider any prepayment plan submitted for approval, and to provide liaison with any insurance carrier.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

Donald N. Sweeny, M.D.: We continue with the recommendations of the Joint Committee.

II. That Michigan Medical Service revert to its original participating agreement, titled "Doctors Enrollment Application with Michigan Medical Service."

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

Donald N. Sweeny, M.D.:

III. That, to assist members of the Corporate Body to carry out their responsibilities, the nominating committee of the Michigan Medical Service will give members of the corporate body information about each candidate for election to the Board of Directors of Michigan Medical Society.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

Donald N. Sweeny, M.D.:

IV. That members of the Michigan State Medical Society be advised of their rights to present problems directly to the Medical Advisory Committee of the Board of Directors of Michigan Medical Service.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

Donald N. Sweeny, M.D.:

V. That the Councilor District Medical Care Insurance Committees be dissolved and that suitable committes at the county level be utilized for the handling of problems of pre-paid medical care insurance.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

Donald N. Sweeny, M.D.:

VI. That the operation of Michigan Medical Service be carried out by the Board of Directors, and that the Michigan State Medical Society and its commitees be utilized in an advisory capacity.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

Donald N. Sweeny, M.D.: Your Reference Committee recommends adoption of the further recommendations of the Joint Committee, (to be found on Page 10) which follows:

1) That the recommendations from the ad hoc Study Committee on Regional Election of Michigan Medical Service Board Members be not accepted, but 2) That Article II, Section 2 of the Bylaws of Michigan Medical Service be amended to provide:

That Michigan Medical Service Board of Directors shall appoint a nominating committee of seven, two of whom shall be members of the Board of Directors and five shall be members of the Corporate Body who are not serving as Directors. The Chairman shall be one of the members from the Board of Directors.

The nominating committee shall submit at least two nominees for each vacancy for the physician members of the Board, but the number of nominees for the lay members shall be left to the discretion of the Board of Directors. The nominees shall be selected, insofar as practicable, on a regional and population basis.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

Donald N. Sweeny, M.D.: The Reference Committee reviewed the problem concerning the remunerations for prolonged and/or complicated cases as set down in the Joint Committee report: **Your reference committee recommends adoption of the recommendations of the Joint Committee** (to be found on page 12) **but amended to read as follows:**

(1) That the existing procedures for remuneration for prolonged and/or complicated cases be clearly defined by the Board of Directors of Michigan Medical Service.

(2) That the Board of Directors of Michigan Medical Service undertake an educational campaign to inform the physicians of these existing procedures and their rights for remuneration for prolonged and/or complicated cases.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

Donald N. Sweeny, M.D.: This Reference Committee considered the resolution "MSMS Contract Approval by House of Delegates" (also to be found on Page 12) which had been referred to the Joint Committee by the 1959 House of Delegates. I will read the "Resolves".

"RESOLVED: That the above noted Authority-to-approve delegated to The Council is hereby rescinded; and be it further

"RESOLVED: That any insurance carrier or prepay-

ment plan organization seeking approval of endorsement of its program by MSMS shall submit the complete text of the policies, for which approval is sought, to this House as a whole, for appropriate action."

Because of the highly technical problems involved in evaluation of contracts, it is believed that this resolution is impractical, and we therefore offer a substitute resolution which embodies basic ideas that are implied by the original resolution as follows:

"RESOLVED: That any change in income ceiling or major change in scope of benefits in any insurance contract be submitted to this House of Delegates for appropriate action."

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

XVII—13c. MICHIGAN MEDICAL SERVICE ANNUAL REPORT

Donald N. Sweeny, M.D.: This reference committee studied in detail the Michigan Medical Service Annual Report on Pages 147 to 166 inclusive, in the Handbook for Delegates of 1960, and the Supplemental Report of Michigan Medical Service to the House of Delegates dated September 25, 1960.

We accept the progress report in the development of the $6,500 family income contract to comply with resolution A passed by this House, September, 1959. Although we recognize the difficulties that have confronted the Board of Directors in all states of development of the M-65 group of contracts, we are critical of the slow progress reported thus far. We also note the statement in the Supplemental Report that "The Board finds itself unable to discontinue the sale of M-75 at the present time or in the near future." We urge that the Board continue its studies of this problem.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded.*]

Ralph R. Cooper, M.D.: Mr. Speaker, I would like to move an amendment to add at the end of the report as printed, after the word "problem", the phrase "and that the Board be requested to present a $6,500 family income contract before the next annual session of the House of Delegates."

Edward J. Tallant, M.D. [Wayne]: I second the amendment.

All those in favor of the amendment say "aye"; opposed "no". The amendment is lost by a vote of 73 to 14.

We will now vote on the motion to adopt this portion of the report.

The Speaker: All those in favor say "aye"; opposed "no". The motion carried.

Donald N. Sweeny, M.D.: Substitute Resolution C of the 1959 House of Delegates (at top of page 148 of the Handbook) has been implemented by the incorporation of a statement of assignment on the Doctor's Service Report.

Compliance has already been made with Resolution No. 7 (page 148:C) concerning biographical sketches of nominees.

It is noted that negotiations may soon be completed through the adoption of a National Account Contract.

Resolution No. 3 (page 149 E) passed by the House of Delegates in 1959 relative to the issuance of income-not-certified policies and freedom of selection of policies has been put into effect.

Resolution No. 30 (page 150:F) concerning the itemization of Blue Shield vs. Blue Cross premium costs has been implemented with considerable unfortunate delay by the distribution of a folder: "Your Blue Cross-Blue Shield Dollar." The public relations aspect of the material in this folder leaves much to be desired.

Resolution No. 15 (page 150:G) requesting limitation of a term of directorship has been met by the Board as indicated in the Handbook.

Since Michigan Medical Service is a non-profit organization instituted for the public good, as a Reference Committee we share a great disappointment that the thoroughly justified request for a 19½ per cent rate increase was not granted in full by the Insurance Commissioner. This is difficult to understand in view of the public demand for liberalization for benefits. The attitude of the Insurance Commissioner discourages proper utilization of present benefits or expansion of future programs. We recognize that every effort should be made by all parties concerned to prevent abuses in the prepayment field. We are distressed that a non-profit corporation developed for the good of the public finds itself in this unfortunate financial situation. We accept the financial statement as given for information.

In consideration of the enrollment section of this report (page 156), we note that approximately 3½ million (or roughly ½ of the citizens of the State of Michigan) are now covered by the M-75 program.

From our review of the report of the Professional Relations Activities of MMS—we commend the effort and urge its continuation.

Mr. Speaker, I move that this portion of this report be accepted.

[*The motion was duly seconded and carried.*]

XVII—13d. REPORT OF THE RELATIVE VALUE SCALE SUBCOMMITTEE

Dr. Sweeny: We accept this as an interim report and await their future conclusions.

Mr. Speaker, I move that this portion of this report be accepted.

[*The motion was duly supported and carried.*]

XVII—13e. RESOLUTION NO. 3—DESCRIPTIVE CODING OF MEDICAL SERVICES

Donald N. Sweeny, M.D.: Your Reference Committee has reviewed Resolutions No. 3 and 46 together, of which I will read the resolving sections. I will read No. 3 first.

"RESOLVED: That the Michigan State Medical Society immediately study and develop more detailed codings of the non-surgical services of medical care based on the diagnosis and treatment of the ailment and comparable in detail to existing codings of surgical services, and to include home, hospital, and office procedures, and be it further

"RESOLVED: That the detailed codings of non-surgical service, home, hospital and office, as soon as developed, shall be incorporated and used as the basis of the description of such services in all negotiations with state or national governmental agencies and all prepayment insurance plans involved in supplying medical service, or the reimbursement of costs of medical care, and be it further

"RESOLVED: That the Michigan State Medical Society shall establish a means of continuing study of the adequate detailed coding of all medical care so that the new procedures and additional descriptions both surgical and non-surgical may be coded and more quickly incorporated into all schedules which depend on such descriptive coding for the supplying or reimbursement of costs of medical care."

XVII—13f. RESOLUTION NO. 46 RE PAYMENT FOR MAJOR MEDICAL SERVICES BY MICHIGAN MEDICAL SERVICE

"RESOLVED: That it is the sense of the House of Delegates, Michigan State Medical Society, that Michigan Medical Service should establish specific fees for services for all major medical services similar to the specific fee schedules in effect for surgical services; and be it further

"RESOLVED: That such specific fee schedules for major medical services be employed in all future negoti-

tions between Michigan Medical Service and/or Michigan State Medical Society and governmental agencies for all prepayment insurance plans or contracts wherein medical service is involved."

This Reference Committee recommends that these resolutions, without comment, be referred to the Relative Value Study Committee of Michigan State Medical Society for its appraisal and recommendations of action thereto.

Mr. Speaker, I move the adoption of this portion of this report.

[*The motion was duly seconded.*]

Ross V. Taylor, M.D.: Mr. Speaker, this Resolution No. 3 was introduced originally because of repeated delays in solving some pressing problems. It seemed essential the principles in this original resolution be approved by the House in order to obtain action. Secondly, the Relative Value Study Committee has been assigned the specific duty of developing a Michigan Relative Value Study. The codings which the Relative Value Committee developed may be adequate, but they may not be as inclusive as contemplated by more detailed study. If the relative value codings are adequate, nothing has been lost. I would further point out that the original resolution requests the continuing action which is somewhat detailed in scope. I would therefore recommend the House approval of a substitute resolution which is identical in context to the original resolution No. 3.

Luther R. Leader, M.D.: Mr. Speaker, the reason I rise to speak to this is because I think what the medical department wants is a study of their fees, etc. Now we feel that we were spending a lot of money in the Relative Value Committee. We wish we were through. We are not. It runs into some several months. As far as our committee can see, and our committee has been given this resolution to study, we feel that first, we are making a study of what these resolutions ask for, and therefore, if you pass this resolution or the amendment to this resolution, you are going to repeat the same thing over with another great expense.

I think the least you could do is see what we do with what they have given us, and then if it is not adequate, at the next session you can ask for a review of what they want.

Ross V. Taylor, M.D.: I move a substitute resolution which is identical to the original Resolution No. 3.

Richard E. Wunsch, M.D.: Second the motion.

Louis J. Bailey, M.D.: Point of order! I think of a substitute motion as being essentially an amendment. The motion that Dr. Sweeny made was to commit and that is a more privileged motion.

The Speaker: We will take the word of the parliamentarian for that. The motion on the floor then is to commit this to the Relative Value Study Committee.

[*The question was put and carried.*]

XVII—13g. RESOLUTION NO. 4—BLUE SHIELD POLICY

Dr. Sweeny: Your Reference Committee reviewed in detail Resolution No. 4, the resolving sections of which I will read:

"RESOLVED: That the Genesee County Medical Society firmly believes that prepayment health insurance on a partial indemnity or a deductible basis should be adopted throughout the State of Michigan, and be it further

"RESOLVED: That the Genesee County Medical Society endorse the report of the Committee for Evaluation and recommend its adoption, and be it further

"RESOLVED: That the Genesee County Medical Society believes that failure of the House of Delegates to act on the above decisions, and failure to exercise the above mentioned recommendations, will mean frequent stopgap changes to appease the public and powerful pressure groups (to keep Blue Shield solvent) thereby leading to chaos, and finally, in desperation, to a request from a misguided public and a frustrated profession, for full government control of medical practice."

This Reference Committee was informed that the presentation of the philosophy of the Genesee County Medical Society relative to Blue Shield policy was accomplished by the introduction of this resolution.

We therefore recommend that it be received for information and no action be taken.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

XVII—13h. RESOLUTION NO. 6—HOSPITAL EMERGENCY CARE

Your Reference Committee has reviewed Resolution No. 6 concerning hospital emergency care. I will read the resolving sections.

"RESOLVED: That the Michigan State Medical Society undertake a study to develop means whereby such "emergency care" can be carried out within the framework of the private practice of medicine, and be it further

"RESOLVED: That the Michigan State Medical Society recommend to the Michigan Hospital Service that it discontinue the practice of paying for routine clinic care in hospital emergency rooms."

This Committee views with alarm the continuing encroachment of hospitals on the private practice of medicine. This Committee recommends that this resolution be referred to The Council of the Michigan State Medical Society for appropriate action, which action is to include consideration by the members of the Michigan State Medical Society who are members of the Board of Trustees of Michigan Hospital Service.

Mr. Speaker, I move the adoption of this portion of this report.

[*The motion was duly seconded and carried.*]

XVII—13i. RESOLUTION NO. 41 RE MMS PAYMENT FOR SURGICAL ASSISTANTS

Donald N. Sweeny, M.D.: Your Committee has considered Resolution No. 41 concerning MMS payment for surgical assistants. I will read the resolving section.

"RESOLVED: That The Council is hereby directed to take such steps as may be necessary to require Michigan Medical Service to pay for 'surgical assistants where required,' in accordance with the Basic Principles for Prepaid Medical Care Insurance, as adopted by this House."

We would substitute the following "RESOLVED":

"RESOLVED: That the Council of the Michigan State Medical Society is hereby directed to advise MMS to reconsider its present method of paying for 'surgical assistants where required.'"

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded and carried.*]

XVII—13j. RESOLUTION NO. 45—SEPARATION AND DIVESTMENT OF THE MICHIGAN STATE MEDICAL SOCIETY FROM THE MICHIGAN MEDICAL SERVICE

Your Reference Committee has considered Resolution No. 45 concerning separation and divestment of the Michigan State Medical Society from the Michigan Medical Service, from which I will read the "RESOLVED":

"RESOLVED: That the Michigan State Medical Society through its House of Delegates establish a committee to use every practical means to explore and study the advisability and all ways and means of legally, ethically, financially, responsibily, and otherwise separating and divesting itself from the direct sponsorship and responsibility for the Michigan Medical Service while at the

same time not jeopardizing the successful future of Blue Shield nor the respect of the medical profession."

This resolution is in direct conflict with a resolution reaffirming MSMS sponsorship of a prepaid medical care insurance program passed by the House of Delegates in 1959. We recommend disapproval of this resolution.

Mr. Speaker, I move the adoption of this portion of this report.

[*The motion was duly seconded and carried.*]

XVII—13k. RESOLUTION NO. 47 RE POLICY FOR PREPAID MEDICAL CARE INSURANCE PLANS

The reference committee considered resolution No. 47 entitled "Policy for Prepaid Medical Care Insurance Plans"—I will read the resolved:

"RESOLVED: That it is the opinion of this House of Delegates that Michigan Medical Service should develop a new contract embracing the following basic principles:

(1) Uphold the original purpose of Michigan Medical Service to spread the cost of medical care to protect the low income group against the cost of serious illness.

(2) Maintain normal patient-physician relationship without the intrusion of any third party.

(3) Eliminate all service contracts except for the low income group.

(4) Preserve free choice for both the patient and the physician, and be it further

"RESOLVED: That it is the opinion of the House of Delegates that such a contract should:

(1) Cover only basic in-hospital medical, surgical, obstetric and anesthesia services.

(2) Permit appropriate riders to cover such extra services, as X-ray, laboratory tests, office surgery, etc., as options for any purchaser who desires to pay the extra premium."

This committee recognizes the general importance of this resolution. It recommends that "Resolved" No. 1 be deleted and that the second "Resolved" be revised to read:

"RESOLVED: That it is the opinion of this House of Delegates that Michigan Medical Service should consider developing a new contract to protect the low income group against the cost of serious illness embracing the following features:

(1) Cover only basic in-hospital medical, surgical, obstetric and anesthesia services.

(2) Permit appropriate riders to cover such extra services as X-ray, laboratory tests, office surgery, etc., as options for any purchaser who desires to pay the extra premium."

In this connection, your committee calls attention to the second recommendation of the Medical Care Insurance Committee "that further study should be made of a basic contract with a low income ceiling" which was previously presented in the report of this reference committee tonight.

Mr. Speaker, I move the adoption of this portion of this report.

[*The motion was duly seconded and carried.*]

DONALD N. SWEENY, M.D.: Resolutions No. 48 and 49 were considered together.

This Reference Committee considered resolutions No. 48 and 49 entitled respectively "Family Income" and "Loading Charges Made on Unit Values," of which I will read the resolving sections.

XVII—13l. RESOLUTION NO. 48 RE FAMILY INCOME—MMS

"RESOLVED: That the present method of income certification be maintained as is, and be it further

"RESOLVED: That the family income principle be made a part of the M-75 contract forthwith or as soon as possible but without determination by management, and be it further

"RESOLVED: That the physician determine the application of the family income principle and when applicable make an additional charge if he so sees fit and be it further

"RESOLVED: That any dispute be handled by an appropriate body empowered to take depositions regarding statements of subscribers."

XVII—13m. RESOLUTION NO. 49 RE LOADING CHARGES MADE ON UNIT VALUES—MMS

"RESOLVED: That the present unit values for M-75 and any future unit values be subject to no conditions or loading factors, and be it further

"RESOLVED: That the 15% loading charge be made a permanent part of the unit values of M-75."

The intentions of these resolutions were not entirely clear to the Reference Committee. It is the feeling of the Reference Committee that the sense of these resolutions has been covered in the discussion of the Supplemental Report of MCIC as follows: "We believe the unit values as recommended by the MCIC for the M-65 group of contracts are based on inadequate statistical information furnished. At the time the unit values for the M-75 series were being established by MSMS Committees, compensation for the difference between the projected annual rate of earnings of the subscriber and the gross annual earnings of the family were taken into consideration. This upward adjustment was necessary because of the amended base for the determination of service benefits. This was estimated to be 15% of the projected annual rate of earnings of the subscriber. This estimate is now thought to have been an arbitrary decision which was based on inaccurate information. We do not think this is binding in the present determination of unit values for the M-65 contracts."

We recommend therefore that no action be taken on resolutions 48 and 49.

Mr. Speaker, I move the adoption of this portion of this report.

[*The motion was duly seconded and carried.*]

DONALD M. SWEENY, M.D.: Medical Care Insurance is a complex subject, with endless technical factors and a variety of philosophical approaches. There is some basis for reasoning that physicians should not be in the insurance business. On the other hand, Blue Shield constitutes medicine's greatest contribution in the public interest. There is a belief that insuring a large portion of the public might establish possible basis for socio-economic control by a government agency. On the other hand, insuring the public well and efficiently is what the public wants and will procure, thereby avoiding the demand for government medicine. It is logical and physicians as individuals may favor one philosophy or another, and emphasize one factor or another.

Blue Shield must avoid capricious change. It has too many contracts in existence and too many individuals concerned, to be subject to change from year to year. Blue Shield is not frozen, but should change its major principles and factors only after very careful consideration. Consequently, it is the duty of the Board of Michigan Medical Service to keep its ship from tilting too frequently and too far. It should be a duty of this Reference Committee to point out to the House of Delegates that it must recommend, to the House for approval, a stable course of action, which of necessity means that resolutions too far from the middle of the road must be disapproved.

The $6500 family income ceiling approved by the House in 1959 was a major change. Its promulgation was too slow, but the delay enabled a more thorough consideration of all facets concerned. It is the opinion of the Committee today, based on findings of the MCIC and reports from the Board of MMS that the $6500 income ceiling is not logical and should be reappraised. The public wants the $7500 ceiling and it should be retained. At least the issuance of $6500 family income contract should continue to be delayed until

further study and analysis show it to be advisable. These facts are the answer of this committee to the question: What has been done to comply with Substitute Resolution A, passed by this House a year ago? (1960 Handbook for Delegates—Page 147)

Therefore, even if this is reiteration, this Reference Committee recommends:

XVII—13n. RECOMMENDATIONS OF REFERENCE COMMITTEE

(1) That the M-75 contract be continued in its present form with changes to be made as necessary.

(2) That further study be made of the $6500 family income contract.

(3) That further study be made of a basic contract with a low income ceiling (Substitute Resolution No. 47).

(4) That this House of Delegates reaffirm its support and sponsorship of MMS as a non-profit organization in the public interest.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, discussed, and carried.*]

Donald N. Sweeny, M.D.: This report which I have presented is the unanimous report of this Reference Committee, and Mr. Speaker, I move the adoption of this report as a whole as amended.

[*The motion was duly seconded.*]

Louis F. Hayes, M.D.: I would like to raise a question, and I would like to preface my question with a couple of remarks. I stand in awe of the magnitude of work done by this committee and I am in great admiration of the facility with which this committee has done its work. I think the like of it has never been seen in this House of Delegates. I would like also to state that I have extremely high regard for all of the people regardless of their philosophies involved in this debate.

I would like to raise this question. Inasmuch as we have taken this excellent report and made one small amendment that makes the doctor of medicine now the judge of family income should we not in justice remove the 15% loading factor which was supposed to have taken care of that and thereby reduce the premiums to the patient? Now this has been stated twice in this reference committee report. On the second page the 15% is explained, and on the remarks made by the committee on the next to the last page this again is stated, and there is in the remarks of the Chairman a very fine statement. Blue Shield must avoid capricious change. I think this is something that has been overlooked by this House of Delegates, and I am really quite sure that it is not something that is going to be overlooked by the Insurance Commissioner.

The Speaker: Thank you. Is there any further discussion of the motion to adopt this report as a whole? If not, all those in favor say "aye"; opposed "no." **The motion is carried,** and I want to take this opportunity to thank Dr. Sweeny and his committee, and I think the House of Delegates owe him a rising vote of thanks.

[*The assembly arose and applauded.*]

The Speaker: I wish also to thank Dr. Carson, Dr. Stubbs, and John Caralucci for their help in helping the committee to develop this report.

XX. ELECTIONS

The Speaker: The Tellers for the evening are Dr. Wunsch, Dr. Stander and Dr. Vanden Berg.

XX—1. COUNCILOR OF THE SECOND DISTRICT

Arthur W. Strom, M.D. [Hillsdale]: Mr. Speaker, I should like to place in nomination the name of a man who has served in this House for years, and who has served on The Council for the last five years, the latter part of this time in a difficult situation as Chairman of the Finance Committee. Oliver B. McGillicuddy has been a diligent Councilor. He has performed excellently for this State Society. He has met all of the communications and all other problems of constituent county societies in the Second District.

It gives me great pleasure to nominate Oliver McGillicuddy to succeed himself for a term of blank years, three I believe, if the previous action of the House is correct, as Councilor of the Second District.

Byron P. Brown, M.D. [Eaton]: I am very proud to second the nomination of Dr. McGillicuddy for Councilor of the Second District.

Member: Mr. Speaker, I move that the nominations be closed and the Secretary be instructed to cast a unanimous ballot for Dr. McGillicuddy.

[*The motion was duly seconded and carried.*]

The Speaker: Dr. McGillicuddy is unanimously elected Councilor of the Second District.

XX—2. COUNCILOR, THIRD DISTRICT

Harvey C. Hansen, M.D. [Calhoun]: Mr. Speaker, the delegates of the Third Councilor District are very proud of the accomplishment of our Councilor representing us in the past term. We certainly wish to again give you one of our best Councilor's to succeed himself indefinitely, Harold J. Meier.

Robert M. Leitch, M.D. [Branch]: Mr. Speaker, it is my great pleasure to second the nomination of Dr. Meier.

R. A. Springer, M.D. [St. Joseph]: Mr. Speaker, I move the nominations be closed and that the Secretary be instructed to cast a unanimous ballot for Dr. Meier.

[*The motion was seconded and carried.*]

The Speaker: Dr. Meier, Councilor for the Third District.

XX—3. COUNCILOR, SEVENTH DISTRICT

K. T. McGunegle, M.D.: I would like to nominate for Councilor from the Seventh District, John J. Coury of Port Huron. We are all sure he will be a great honor to this Society.

Charles W. Oakes, M.D. [Huron]: I would like to second that nomination of Dr. Coury.

Member: I move the nominations be closed and that the Secretary be instructed to cast a unanimous ballot.

[*The motion was seconded and carried and Dr. Coury was declared Councilor of the Seventh District.*]

XX—4. COUNCILOR, NINTH DISTRICT

Gerald A. Drake, M.D. [Northern Michigan]: First, I would like to express our regret over the resignation of Dr. Pike. He will be absent from our District for three years following which we hope you give him back to us. I would like to place in nomination the name of Robert V. Daugharty from Cadillac. Dr. Daugharty is a respected member of the profession. He was a member of this House of Delegates ten years. That experience should be valuable to The Council.

Frank H. Power, M.D.: I wish to second the nomination of Robert Daugharty of Cadillac.

Frank H. Power, M.D.: I move the nominations be closed and a unanimous ballot be cast for Dr. Daugharty.

[*The motion was seconded and carried, and Dr. Daugharty was declared Councilor of the Ninth District.*]

XX—5. COUNCILOR, TWELFTH DISTRICT

Eugene R. Elzinga, M.D. [Marquette Alger] I would like to express the appreciation of the work that retiring Dr. Montgomery has done for our district, and also to nominate Dr. James R. Dehlin of Delta County.

Donald D. Finlayson, M.D.: I will second the nom-

ination and move the nominations be closed and that a unanimous ballot be cast for Dr. Dehlin.

[*The motion was seconded and carried and Dr. Dehlin was declared Councilor of the Twelfth District.*]

XX—6. COUNCILOR, FIFTEENTH DISTRICT

WALTER J. ZIMMERMAN, M.D. [Oakland]: Last year on the recommendation of the Fifteenth District this body elected Dr. Bob Mason of Birmingham to fill the unexpired term of Dr. Wiley who resigned to become Secretary of the Society. Dr. Mason has carried out his duties in exemplary fashion in the Fifteenth District. I again nominate Dr. Robert J. Mason to succeed himself on The Council.

EDWARD G. SIEGFRIED, M.D. [Macomb]: I would like to second the nomination of Dr. Mason.

MEMBER: Mr. Speaker, I move the nominations be closed and that a unanimous ballot be cast for Dr. Mason as Councilor of the Fifteenth District.

[*The motion was seconded and carried, and Dr. Mason was declared Councilor of the Fifteenth District.*]

XX—7. COUNCILOR, SIXTEENTH DISTRICT

EDWARD J. TALLANT, M.D. [Wayne]: I wish to place in nomination the name of Wyman C. C. Cole as Councilor for the Sixteenth District.

MILTON R. WEED, M.D.: I would like to second the nomination of Dr. Cole and move that the nominations be closed and a unanimous ballot be cast for Dr. Cole.

[*The motion was seconded, carried, and Dr. Cole was declared Councilor of the Sixteenth District.*]

XX—8. DELEGATES TO AMERICAN MEDICAL ASSOCIATION

RICHARD E. WUNSCH, M.D.: Mr. Chairman, I would like to place in nomination the name of Dr. William Bromme with whom you are all familiar. He has served well as Councilor, and we believe he will serve well in this job.

RALPH R. COOPER, M.D.: I would like to second the nomination of Dr. Bromme.

CLARENCE I. OWEN, M.D.: It is a great pleasure for me to nominate Dr. Bob Novy to succeed himself as delegate to the American Medical Association. All of you know Bob very well. I sat with him in the AMA House and watched his work, and he is a great credit to our state. It is with extreme pleasure that I present his name.

LUTHER R. LEADER, M.D.: Mr. Speaker, I would like to second the nomination of Dr. Novey.

ROBERT M. LEITCH, M.D.: Mr. Speaker, it is a pleasure for me to place in nomination Dr. George W. Slagle of Battle Creek who is presently a delegate to the AMA. For many years he was a delegate to this body, and many years as Councilor, and as you all know, Past President of Michigan State Medical Society.

MEMBER: I would like to second the nomination of Dr. Slagle.

RALPH A. JOHNSON, M.D.: I move the nominations be closed and a unanimous ballot be cast for Drs. Bromme, Novy and Slagle for AMA Delegates.

[*The motion was seconded and carried, and Drs. Bromme, Novy and Slagle were declared Delegates to AMA.*]

CLARENCE I. OWEN, M.D.: Mr. Chairman, I request the privilege to interrupt. Dr. Wyman Barrett served his last session for the State of Michigan. I would like to move that this body express its thanks to Dr. Barrett for his many years' service as delegate to the AMA. The only reason he wasn't chosen again was by his own request to retire at this time. *(Applause)*

RALPH A. JOHNSON, M.D.: I would like to second that recommendation and have it unanimously adopted by the House.

XX—9. ALTERNATE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

JOHN G. SLEVIN, M.D.: Mr. Speaker, I would like to place in nomination for alternate delegate to the American Medical Association an incumbent well known to you who has been past president of his county society and is at the present time the chairman of the very important Mediation Committee, Dr. Luther Leader.

HERBERT W. DEVINE, M.D. [Wayne]: Mr. Speaker, I would like to second the nomination of Dr. Leader.

FRANKLIN L. TROOST, M.D.: Mr. Speaker, I would like to place in nomination a man who has shown the society how hard and how well he can work. He is a diligent, careful capable worker. I think his ability should be further used. Because of his ability I would like to nominate Dr. Max L. Lichter.

LOUIS F. HAYES, M.D.: I would like to second the nomination.

GEORGE T. BRADLEY [Wayne]: I would like to place in nomination the name of Dr. Don N. Sweeny.

SIDNEY ADLER, M.D.: I would like to second the nomination of Dr. Sweeny.

DONALD R. SMITH, M.D. [Dickinson-Iron]: I would like to place the name of Dr. John Heidenreich to succeed himself as alternate delegate to the AMA. He served on this body for a number of years and on various committees. We feel he would make a good alternate delegate to the AMA.

CLARENCE I. OWEN, M.D.: Mr. Chairman, it is a pleasure to second the nomination of Dr. Heidenreich.

LOUIS F. HAYES, M.D.: Mr. Speaker, I move the nominations be closed.

[*The motion was seconded and carried and the delegates cast their ballots.*]

THE SPEAKER: Results of your balloting for Alternate Delegates to the AMA are the election of Drs. Leader, Heidenereich and Sweeny in that order.

XX—10. PRESIDENT-ELECT

R. WALLACE TEED, M.D.: Mr. Chairman, members of the House of Delegates: It is a real pleasure and privilege to put in nomination for President-Elect for the Michigan State Medical Society the name of Otto K. Engelke of Ann Arbor. Dr. Engelke is a native of Cincinnati, graduated from the University of Cincinnati Medical School in 1933, took his internship in New York City, and then practiced general medicine in Dearborn for three years where he developed his ideas of the private practice of medicine.

Later he transferred to the University of Michigan where he took graduate work in public health, securing the Degree of Master of Public Health. He comes from a medical family. His father-in-law, his brother-in-law and his nephew are all physicians. His wife is not only the wife but also the daughter of a physician. He has been a member of the Washtenaw County Medical Society for over twenty years and has held important positions in the Society.

He has also been a member of the House of Delegates for fourteen years, during which he has been chairman of the Reference Committee on Hygiene and Public Health for a number of years and has carried out valuable work for the House of Delegates.

He has been Chairman also, in 1956 and 1960, of the House of Delegates Financial Investigating Committee and you are familiar with his report today. He is interested in sound fiscal policy and will carry on in the same way. He is also a Past President of the Michigan Health Council which is a cooperating organization with the Michigan State Medical Society. At home he is Past President of the Ann Arbor Community Chest, is Assistant Professor at the University of Michigan where he has an opportunity to interview students and sell them on the philosophy of the private practice of medicine.

Last time when a President of the Michigan State

Medical Society came from Washtenaw County was in 1942 when Dr. H. H. Cummings was your President. I believe that it is time again for a native of Washtenaw County to be elected to the Presidency of this Society.

HENRY A. SCOVILL, M.D. [Washtenaw]: I wish to second the nomination of Dr. Otto K. Engelke of Washtenaw County. You are all familiar with Dr. Engelke's excellent, faithful service in this House for several years. He is President-Elect of his own County Society and held in very high esteem by the practicing physicians of his community. The relations between the Health Department which he heads and the doctors in his county are exceptionally good because of his tact and leadership.

Dr. Engelke will be a dynamic leader of this Society.

RALPH A. JOHNSON, M.D.: Mr. Speaker, this, I trust, will be my swan song as a member of this House of Delegates. I have had in my opinion the highest honor that this House affords, which is to serve you at the national level as a member of the House of Delegates of the American Medical Association.

Early in my career as a delegate from Wayne to this House, I had the good fortune to meet and know Dr. Engelke. He has been a sterling member of this House. That factor of his character has been recognized by every speaker, by appointment to Reference Committees and other responsible duties. I urge every delegate to read carefully the Engelke report which is perhaps the most thorough, careful and considered report on the financial structure of our state society that we have had the privilege of reading. In my humble opinion, Dr. Engelke possesses most of the sterling qualities possessed by his successors. It is with privilege and pride that I second the nomination of Dr. Engelke.

DE VERE R. BOYD, M.D. [Muskegon]: Perhaps once in a lifetime an occasion presents itself at which time you can say the things you would like to say about a friend before such a distinguished group of physician colleagues as are present here tonight. I have some things to say about one of our mutual friends, and when I have completed these comments I am going to place his name in nomination for the Presidency of the Michigan State Medical Society.

The friend of whom I speak was born in Muskegon on December 5, 1896. Upon graduation from Muskegon High School, the University of Michigan and a stint in the United States Army Air Force, he embarked upon a career of being a Doctor of Medicine by graduating from the University of Michigan Medical School in 1923.

It was almost expected that he would be a doctor because his father before him was a doctor—a very distinguished doctor. In fact, a doctor who was the President of this Michigan State Medical Society, and that was in 1933.

After receiving his medical training and interning at Memorial Hospital in Philadelphia, he returned to Muskegon and began practice in 1923. Always alert to the need for more knowledge in order to meet the demands occasioned by our swiftly advancing science. this doctor took postgraduate work at the University of Michigan, at Barnes Hospital, St. Louis, at the Cook County Hospital in Chicago, and at Massachusetts General Hospital in Boston. His scientific attainments were recognized by his election as a Fellow of the American College of Physicians in 1930, and became a member of the Board of Internal Medicine in 1937.

Our friend became identified with the American Diabetes Association in 1940, and served as President of the State Society of Diabetes. His work with this organization was exemplary, and he formed a pattern of cooperation with the public whereby on a community-wide and state-wide basis a program was begun that carried the soundness of scientific knowledge, with the virtue of voluntary service.

Our friend's services were also well recognized in his own community. He served as President of Muskegon County Medical Society. He also served as secretary of our local society, and in 1953 he was chosen to represent his District Council of Michigan State Medical Society.

For seven years he has distinguished himself on that body and for five years has been on the Executive Committee. He has been on the County Societies Committee.

Probably one of the most outstanding achievements of our friend, which will go down in history, was his part in organization of Michigan Association of the Professions, and his choice by the members of this group as their first president, I think, speaks very highly of him. Under his leadership the MAP has already become a dynamic force in our state and forerunner of great service in this country.

I could elaborate further about his work with the American Red Cross, a civic leader, and his remarkable ability to resolve problems with a combination of forthrightness and humor, founded on a basis of strong sincerity. I have introduced this man who needs no introduction, but it has been a pleasure to review his outstanding record. I now place in nomination before this group the name of William M. LeFevre, M.D., of the State of Michigan.

FRANK D. JOHNSON, M.D.: Mr. Speaker, I wish to second the nomination of Dr. William LeFevre. First of all, I listened with pride to the nominating speech, and second of Dr. Otto Engelke. Indeed, this House of Delegates is proud of that man. He has done an outstanding job in the House of Delegates and I wish that I could do as well in talking about LeFevre as his seconder as these men did for Dr. Otto Engelke. I am not the speaker that these other men were, and I don't think I could do so. I do sincerely hope that we will not lose Dr. Engelke from this House of Delegates.

I believe that Dr. LeFevre is deserving of this honor. He has served faithfully and well as a Councilor, and he has been a man of big heart. He pushed himself to the limit, and I believe is deserving of this honor. He is not as young nor as vigorous as Dr. Engelke and this is perhaps his last opportunity for this high honor.

I take great pleasure in placing the name of Dr. LeFevre in nomination for President-Elect for this Society.

LAWRENCE A. DROLETT, M.D.: It is with a great deal of pleasure that I note the work and responsibility that Dr. LeFevre has given to this society, and I am highly honored to second the nomination of Dr. Bill LeFevre.

MEMBER: I move the nominations be closed.

[*The delegates cast their ballot for President-Elect.*]

THE SPEAKER: The President-Elect is Dr. Engelke.

[*Dr. Engelke was escorted to the platform.*]

OTTO K. ENGELKE, M.D.: At a time like this any words seem inadequate. I think I would not be telling the truth if I didn't say that this is one of the greatest moments of my life. I just wish I could share them now with my wife, Maria, who has really been in the practice of medicine, too, for many, many years, and has worked awfully hard for the improvement of medical practice in these United States. If she were here, I am sure that she would recognize that this group is as fine an organization as a man could ever have the privilege of working for. I certainly recognize this. I shall have a very difficult task to try to fill the shoes of my distinguished predecessors. I shall work as hard as I know how, to justify the confidence you have placed in me. Thank you so so much. *(Applause)*

JAMES B. BLODGETT, M.D.: Mr. Speaker, I would like to move a vote of commendation and appreciation to the Speaker, the Vice Speaker and their supporting staff, for their tolerant and efficient conduct of the deliberations of this House of Delegates.

[*The motion was duly seconded.*]

(Applause)

THE SPEAKER: This was rather unexpected. Thank you very much, and I shall speak for the Vice Speaker and the staff, too, I believe. There is considerable work associated with these jobs, but I think we all enjoy it,

and it is you gentlemen out there in front that make it easy for us up here.

J. Duane Miller, M.D.: This again is a great personal privilege. A. Verne Wenger, M.D., who was the oldest delegate in this House and has the longest record of attendance is now unable to attend. He asked me to personally present his regards to the House, and thank the members for all the years of fine association he had with them. Verne is so short of breath now, that he is no longer able to attend. Thank you, Mr. Speaker.

XX—11. SPEAKER OF THE HOUSE OF DELEGATES

The Vice Speaker: The position of Speaker of the House is now open for nominations.

Floyd B. Levagood, M.D.: It is my privilege, Mr. Speaker, to have the opportunity and the honor to nominate the man for Speaker of the House. The man which I wish to place in nomination is an individual who has great renown as a physician, and all of you have seen the excellent work and tremendous work and organization for which he is responsible in this House. This man has served as Vice Speaker of this House for three years. The excellence of his job speaks for itself as we have all sat here in witness of this accomplishment.

At this time, Mr. Speaker, I would like to place in nomination the name of James Lightbody as Speaker of the House. *(Applause)*

Lawrence A. Drolett, M.D.: Mr. Vice Speaker, I would like to support the motion for Dr. Lightbody as Speaker of the House.

Louis F. Hayes, M.D.: I move the nominations be closed.

The Vice Speaker: Hearing no more nominations, all in favor say "aye"; opposed "no." *(Applause)*

The Speaker: Gentlemen, thank you very much for this expression of confidence. It makes me feel very happy. I would like to take this opportunity to thank the Chairman and members of the committees of the House of Delegates that worked during this past year and came in with such excellent reports.

This is the first year, as you know, that we have had working committees that have had to work during the regular year, and there is no doubt that it seems that the House of Delegates is getting into more committee work. We have had Committee on Committees and it seems the more Committee on Committees we have, the more Committees we get, and so it is difficult to know just where we are going in relation to committee work, but perhaps the next report of the Committee on Committees will take care of that.

XX—12. VICE SPEAKER OF THE HOUSE OF DELEGATES

John W. Rice, M.D.: Mr. Speaker, one year ago I ran against Dr. Falls for Vice Speaker of the House of Delegates. Very fortunately he was elected, and I think that he has done such an excellent job that I would like to renominate him for that position as Vice Speaker of the House of Delegates.

Louis F. Hayes, M.D.: Mr. Speaker, I would like to second the nomination as the other losing candidate last year.

The Speaker: It has been moved and seconded that nominations be closed and the unanimous ballot be cast in favor of Dr. Falls.

All those in favor say "aye"; opposed "no." Congratulations. *(Applause)*

The Vice Speaker: I am certainly honored indeed, by my defeated opponents, and I want to express my sincere appreciation of the opportunity for serving you in this capacity. I have an excellent teacher. I have an excellent chance to learn the ropes of this job from the Speaker. As you can see, I am a novitiate. Certainly it has been a pleasure. It is certainly an education to be here, and may I second what has been intimated this evening. The organizational ability of Jim is amazing. I think this meeting went extremely smoothly chiefly because of his arrangements, his organizational ability and I couldn't have a better teacher, but I hope to try and meet some of the requirements of his task making. *(Applause)*

The Speaker: I would like to thank the office staff, all the stenographers, particularly Dick Phileo who assisted me so much during the past two months in organizing the work of this House, and all who helped to make this House of Delegates a success. I really think we should give them a vote of thanks for that. *(Applause)*

XXI. ADJOURNMENT

The Speaker: I will accept a motion to adjourn.

[*The motion was moved, severally seconded, and the House of Delegates adjourned at twelve o'clock midnight.*]

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Roster of Committee Personnel, 1960-61

Committees of the House of Delegates

Committees of the Society

Committees of The Council

(This number is composed of two sections, of which this is Section 2)

Michigan State Medical Society

OFFICERS OF THE SOCIETY

1960-1961

President.....K. H. JOHNSON, M.D.....Lansing
President-Elect.....OTTO K. ENGELKE, M.D.....Ann Arbor
Secretary.....D. BRUCE WILEY, M.D.....Utica
Treasurer.....W. A. HYLAND, M.D.....Grand Rapids
Speaker.....J. J. LIGHTBODY, M.D.....Detroit
Vice Speaker.....H. F. FALLS, M.D.....Ann Arbor

THE COUNCIL

H. J. MEIER, M.D., *Chairman*, Coldwater
T. P. WICKLIFFE, M.D., *Vice Chairman*, Calumet
D. BRUCE WILEY, M.D., *Secretary*, Utica

	District		*Term Expires*
A. E. SCHILLER, M.D.	1st	Detroit	1961
O. B. McGILLICUDDY, M.D.	2nd	Lansing	1963
H. J. MEIER, M.D.	3rd	Coldwater	1963
WM. A. SCOTT, M.D.	4th	Kalamazoo	1961
C. ALLEN PAYNE, M.D.	5th	Grand Rapids	1961
H. H. HISCOCK, M.D.	6th	Flint	1961
JOHN J. COURY, M.D.	7th	Port Huron	1962
E. S. OLDHAM, M.D.	8th	Breckenridge	1962
ROBT. V. DAUGHARTY, M.D.	9th	Cadillac	1963
O. J. JOHNSON, M.D.	10th	Bay City	1962
W. M. LeFEVRE, M.D.	11th	Muskegon	1963
JAMES R. DEHLIN, M.D.	12th	Gladstone	1963
T. P. WICKLIFFE, M.D.	13th	Calumet	1963
B. M. HARRIS, M.D.	14th	Ypsilanti	1964
R. J. MASON, M.D.	15th	Birmingham	1963
WYMAN C. C. COLE, Sr., M.D.	16th	Detroit	1963
W. W. BABCOCK, M.D.	17th	Detroit	1963
WILLIAM BROMME, M.D.	18th	Detroit	1964
K. H. JOHNSON, M.D.	*President*		Lansing
OTTO K. ENGELKE, M.D.	*President-Elect*		Ann Arbor
J. J. LIGHTBODY, M.D.	*Speaker*		Detroit
H. F. FALLS, M.D.	*Vice Speaker*		Ann Arbor
MILTON A. DARLING, M.D.	*Past President*		Detroit

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T. P. WICKLIFFE, M.D. Vice Chairman
W. M. LeFEVRE, M.D. Chairman, County Societies Committee
B. M. HARRIS, M.D. Chairman, Publication Committee
O. B. McGILLICUDDY, M.D. Chairman, Finance Committee
J. J. LIGHTBODY, M.D. Speaker
H. F. FALLS, M.D. Vice Speaker
K. H. JOHNSON, M.D. President
OTTO K. ENGELKE, M.D. President-Elect
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Chairman
Jack N. Grekin, M.D. Detroit
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Winslow G. Fox, M.D. Ann Arbor
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Charles M. Bell, M.D. Grand Rapids
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Chairman
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Paul Van Portfliet, M.D. Grand Rapids
Chairman (Opth.)
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